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Critiques, in the form of short articles and letters on any aspect of psychological or psychotherapeutic theory or practice, are always welcome. They will be peer reviewed.

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Securing Human Rights in the Psychiatric Field by Utilizing Advance Directives

Peter Lehmann

SUMMARY: Psychiatry as a medical (and natural scientific) discipline cannot do justice to the expectation of solving mental problems that are largely of a social nature. Its diagnostic methods obstruct the view of the real problems of individuals in society. Its propensity and practice to use force constitutes a threat against the human right to bodily integrity. People with physical medical diagnoses have the right to say no; the same right is denied to people with psychiatric diagnoses. So they need to protect themselves by special means.

KEY WORDS: discrimination, citizens' rights, coercion in psychiatry, advance directives

'Laws on equality of treatment should be adopted' was one recommendation of the study *Harassment and Discrimination Faced by People with Psycho-social Disability in Health Services*. This study was conducted from 2001 to 2005 on behalf of the European Commission. Those involved were organisations of users and survivors of psychiatry and organisations of psychiatric workers and relatives of psychiatric patients, from numerous countries: Mental Health Europe, Pro Mente Salzburg (Austria), MIND (England & Wales), Clientenbond (The Netherlands), FEAFES (Confederación Española de Agrupaciones de Familiares y Personas con Enfermedad Mental – Spain), BPE (Bundesverband Psychiatrie-Erfahrener e.V. – Germany) and ENUSP (European Network of (ex-) Users and Survivors of Psychiatry), as well as the Belgian research institution LUCAS (Belgium). The result of the study was evidence that all over Europe, people with mental health problems (or people who are considered mentally ill or disabled) are discriminated against, i.e., treated less favourably than people with medical diagnoses; in doctors' practices of all kinds, in hospitals; in emergency

This paper is based on a workshop via Skype with the facilitator Phil Thomas at the Conference of the International Network of Treatment Alternatives for Recovery (INTAR), Liverpool, June 25, 2014

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units; and in psychiatric clinics. They experience discrimination in different forms: hostility; physical problems not being taken seriously; psychiatric drugs prescribed without informed consent; complaints dismissed as part of pathology; the right to access their own treatment records denied; and threats of discharge, separation, forced treatment, or higher dosages of psychiatric drugs if they do not accept prescribed treatment.

In order to enable people with mental health problems to enjoy full citizens' rights, their organizations should be involved in policy-making at all levels. Legislation on discrimination and boards of appeal were demanded from politicians, administrative authorities, and organized psychiatry:

Laws on equality of treatment should be adopted and funds provided so that these laws can be put into practice. One major objective is to adopt laws that guarantee the respect of human rights in a pro-active way. These laws should focus on the protection of human dignity, the right not to be violated, the right to self-determination, the right to privacy and the right to respect. For example through legal protection of advance directives ... (Action Project, 2005).

Legal protection of advance directives in Germany

In Germany, people who want effective legal protection from violation of their bodily integrity – usually through violent administration of psychiatric drugs – or even protection from unwanted psychiatric examination can do this by executing advance directives. In 2009, when the national guardianship law was reformed, it included a provision for advance directives for health care. Under the revised law, an adult considered capable of consent has the right to affirm in writing ‘independently of the type and stage of an illness’ whether he or she ‘assents or disagrees with treatments, diagnostic procedures or medical interventions that are not immediately forthcoming at the time of this declaration.’ Literally, the German Civil Law Code states:

Advance Directive for Health Care

1) If an adult considered capable of consent declared in written form, whether he or she assents or disagrees with treatments, diagnostic procedures or medical interventions that are not immediately forthcoming at the time of the declaration (advance directive for health care), then the guardian will investigate, whether these determinations apply to the current situation of life and treatment. If this is the case, then the guardian has to enforce the will of the person under guardianship in its expression. An advance directive for health care can be withdrawn informally and at any time.

- 2) If no advance directive for health care is available, or if the determinations of an advance directive for health care do not apply to the current life situation and treatment situation, then the guardian must investigate the treatment wishes or desires of the person under guardianship to determine that individual's presumed will and decide on this basis whether he or she consents to a medical measure in accordance with section 1 or whether he or she forbids it. The presumed will has to be determined based on concrete indications. In particular, earlier verbal or written expressions, ethical or religious convictions and other personal moral values of the person under guardianship must be considered.
- 3) Sections 1 and 2 apply independently of the type and stage of illness of the person under guardianship.
- 4) Nobody can be obligated to establish an advance directive for health care. Production or execution of an advance directive for health care must not be made a condition of a contract (BGB, 2009).

Looking back

After publishing, lecturing, and teaching lawyers and politicians for decades, mainly in the German-speaking countries, the campaign for legal protection of the psychiatric will, started in 1983, finally succeeded. Before people start to reply, 'Not possible in my country,' they should take a look at the developments in Germany. The campaign for the legal protection of advance directives took nearly a quarter of a century. People often said there was no chance of advance directives working in Germany.

In 1983, the independent self-help organisation Irren-Offensive (Lunatics' Offensive) – then an undogmatic group of survivors of psychiatry – received the article 'The Psychiatric Will: A New Mechanism for Protecting Persons Against 'Psychosis' and Psychiatry,' by Thomas S. Szasz (1982). Szasz proposed to translate the article into German and publish it. In his article, he referred to the idea of Walter Block, an Austrian school economist, anarcho-libertarian philosopher and Professor of Economics at Loyola University New Orleans, that it should be possible to apply the mechanism of protecting a person's last will to involuntary psychiatric treatment.

Unmentioned by – and perhaps unknown to – Szasz, two decades earlier the American former psychiatric patient Mary Ellen Redfield (1964) had drafted and published an advanced directive to protect herself from unwanted psychiatric treatment. In her article 'Upholding Psychiatric Advance Directives – 'The Rights of a Flea,' Laura Ziegler, past president of the National Association of Rights, Protection and Advocacy (US), recognised Redfield as the first to publish about this issue:

In 1964, Mary Ellen Redfield self-published *Will for Living Body*, a draft contract with doctors and lawyers that authorizes them to act as temporary guardians if she becomes comatose or of unsound mind. They are pledged to 'secure immediate remedial legal aid' should she fall into the power of doctors who will not honor its terms: refusal of all forms of psychiatric treatment, including those not yet invented. She exempts and welcomes consensual psychotherapy, and invalidates any consent given while drugged or of unsound mind. Declaring 'NO FAITH' in psychiatry she prohibits imposed alteration of her mind, in the expressed faith that she is sovereign over her psyche and soul (Ziegler, 2007, p. 318).

Nevertheless, Szasz' article was translated into German, and – supported by a grant of Netzwerk Selbsthilfe e.V. (Network Self-help, Inc.) – published and distributed as a booklet (Szasz, 1987). The booklet included a form, which had been discussed and developed with Berlin lawyer Hubertus Rolshoven (Lehmann, 2003). The form included a legal instruction to psychiatric workers, space for personal data, different options, and space for referring to personal experiences to justify and strengthen the decisions about specific desired or rejected forms of treatment – especially specific psychotropic drugs or classes of psychotropic drugs. There was no law to cite except the criminal law, which defines each intrusion on bodily integrity as a criminal act which loses its criminal character only if there is informed consent or if there is a life- and health-threatening emergency where people are unable to give consent and the psychiatrist believes that afterwards, when the person is in a rational state again, he or she would surely agree with the psychiatrist's decision. Probably this legal construction is similar in most countries.

The idea was, if there is a statement written by the person while in a state of unquestioned normality/rationality and the psychiatrist is aware of this statement (i.e., after it was handed over in the presence of a witness or sent by registered mail), it will be made absolutely clear to the psychiatrist that the person would not agree afterwards with the treatment without informed consent. Otherwise, the psychiatrist could be subject to civil and criminal liability. Since it would always be uncertain what a judge would decide, the psychiatrist would be aware of standing with one foot in prison.

In the decades that followed, information about the psychiatric will was distributed, articles were written, and booklets were published. Activists went to hearings, gave lectures at conferences and for political parties, and initiated and facilitated public discussions. Of course, the surprise was great when the German parliament finally integrated the concept into the guardianship law and recognized the psychiatric will.

Not possible in your country?

In discussions with critical people in the psychiatric field, the reaction often was – and is – ‘Not possible in my country,’ because it has no special law that affirmatively recognises and protects a psychiatric advance directive. If you look at the German experience, it took some education to teach people, including lawyers, that although the criminal law could and should be the legal basis for advance directives, because of the usual discrimination against psychiatric patients, it is better if the law specifically recognises advance directives like the psychiatric will.

Additionally, in Germany, articles and books were published about the massive dangers caused by psychiatric drugs, especially by neuroleptics, the drugs mainly used for coercive treatment. In earlier years, jurists’ perceptions of the illegal violent administration of psychiatric drugs were undermined by the myth that ‘people with psychoses need neuroleptics like diabetics need insulin.’ Why should they fight for a right to say no to insulin treatment? But over the years, the interested public was educated about neuroleptic-induced obesity and disorders of fat metabolism; high blood pressure and insulin resistance (which may develop into an exceptionally dangerous metabolic syndrome associated with a high risk of massive vascular diseases, myocardial infarction, and apoplectic stroke); chronic deficit-syndrome (neuroleptic apathy syndrome or ‘broken wing’-syndrome); suicidality; delirium; breast cancer; malignant hyperthermia; neuroleptic malignant syndrome; cirrhosis of the liver; chronic diabetes; agranulocytosis; thromboses and embolisms; cardiac complications of all kinds; damage to the retina, the cornea and the optic nerve; loss of teeth; asphyxia; tardive psychoses and dyskinesias; apoptosis (death of brain cells) and increased mortality (Lehmann, 2013). So the argument that violent administration of psychiatric drugs is good for your health was finally doubted by judges.

Different judgments of the Federal Constitutional Court of Germany denied, in individual cases, psychiatrists the right to forcibly administer their drugs because of the substantial violation of the patient’s fundamental right to life and physical integrity. The court called this long-time practice illegal and demanded a new legal basis, which must conform to the stipulations of the UN Convention on the Rights of Persons with Disabilities (CRPD).

As a consequence, the Central Ethics Commission of the German Federal Medical Society now demands that more attention be paid to the patient’s moral values and beliefs. Patients’ subjective perspectives cannot simply be replaced by an ‘objective view’ and medical discretion. If the ‘illness’ impairs the patient’s assessment regarding the usefulness of a medical intervention, what is relevant then is ‘... the moral values the patient would have (or had previously), when in

a condition of capacity to give informed consent for medical treatment while they were not impaired by illness' (Zentrale Ethikkommission, 2013, p. A1336).

The UN CRPD, ratified by many countries' governments and thus legally binding, forbids legal discrimination against people with disabilities (including those with psychiatric diagnoses) and demands a move from substitute decision-making to supported decision-making (see Minkowitz, 2013).

In 'Article 12 – Equal recognition before the law', the UN CRPD, which entered into force on May 3, 2008, states:

- States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law
- States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life
- States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity (United Nations Enable)

Just like people with physical medical diagnoses, people with psychiatric diagnoses must have the right to refuse unwanted medical interventions. Rolf Marschner, a German lawyer explains:

In article 12 of the UN CRPD the prohibition of discrimination for the field of legal capacity and right to execute it is concretised, and thus the capacity to give informed consent for medical treatment. Namely, in article 12 the execution of force is not mentioned directly. But the recognition of the legal capacity of disabled persons and their right to execute it on an equal basis before the law with others means that disabled persons can decide like others about their residence and their treatment, and namely independent from the type and occurrence of their disability. Thus this works for mentally disabled and mentally ill persons. Insofar as the UN CRPD also forces a rethinking of familiar legal concepts in regard to the term of incapacity to give informed consent for medical treatment, because, from the consent for medical treatment by a legal guardian, direct legal consequences (legal limitations) can be deduced from the disability itself. (...) Article 12 section 3 of the UN CRPD demands to offer the formulation of an advance directive or the arrangement of a treatment contract (Marschner, 2013, pp. 220–1).

What is evolving is a right for people who might become targets of forced psychiatric treatment to decide beforehand how they want to be treated and how they do not want to be treated, or who are the persons they trust to make decisions in states of mental emergency, when their own decisions are not accepted as

rational. So advanced directives are regarded as an effective way to create equal recognition before the law for people considered presently incapable of consent.

Self-help virtues of advance directives

As described above, people now can protect themselves from unwanted psychiatric interventions, subject to limitations concerning the difference between law and justice, and the fact that the totality of all possible human and emotional conflicts cannot be solved in advance by a written statement.

To consolidate this success, it is advisable to base advance directives on individual experiences of adverse effects from psychiatric drugs (or electroshock), as well as propose how to respond to emotional crises with measures not involving psychiatry. By anticipating courses of crises and their resolution, advance directives also have important self-help virtues. People no longer see themselves as a function of disturbed genes, metabolism, families, neighbours, policemen and other entities. They now see themselves as subjects who can plan their lives themselves. They have a better chance of not ending up in the doctor's office again so quickly when they learn to understand their personal involvement in the creation of their life-history and how to manage their problems and ensure that their wishes are put into effect. Miriam Krücke, a German student of psychology, wrote a thesis about the use of advance directives, and interviewed some people who had produced advance directives about their failures and benefits. She stated:

Advance directives stimulate a more differentiated approach to the course of the crisis, including early warning signs, habitual responses and appropriate alternatives. In the same manner, the recourse to professional services can be organized before the event. The current development of an informed opinion results from a systematic review of past experiences. 'The idea was also to find out at what point the course had been set, to what extent I myself was involved, basically the point when I – and I can do this now looking back – could have already recognized what kind of conflict situations I was getting into. I have learned to see clearly how my crises have developed and how I can behave and which people can help me. My psychiatric will specifies what kind of support I want instead of psychiatric drugs. I certainly consider the possibility of a relapse ahead of time. I have given a great deal of thought to the causes of my madness and to alternative means of dealing with it.' (Krücke, 2007, pp. 99–100 / 2014).

Meanwhile, in Germany, there are various forms for advance directives, which are offered from different legal bodies. Some are useful, while others seem silly (Lehmann, 2014, p. 46). People have to be careful, and they should

mix components from different forms, according to their different personal experiences and values. Over the years, there have been both positive and negative experiences with psychiatric advance directives. The last two pieces of information about advance directives received by the author of this paper were about a psychiatrized psychiatrist whose advance directive was ignored and who subsequently sued for damages (the case is still undecided), and about another psychiatrist who expressed his fear that patients with advance directives forbidding examination and forbidding administration of psychiatric drugs could be committed to his ward. Implementing humane alternative treatment could solve so many problems (Stastny & Lehmann, 2007; 2014).

The development of advance directives in Germany demonstrates that not only is it sometimes possible to uphold autonomy through the judicial system and to overturn discriminatory statutes, but that advance directives have extraordinary potential in the struggle for self-determination and toward securing the human right to bodily integrity for people targeted for psychiatric intervention.

Update (October 2014)

On September 23, 2014, the German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN) published an 'Ethical statement on self-determination and compulsion,' in which they publicly admitted the effectiveness of advance directives:

Advance directives are also obligatory in mental illnesses, as long as the legal conditions are fulfilled (among others, written form, given ability for self-determination at the time of the drawing up). Their legally binding effect protects patients so that their treatment options will not be ignored, but also highlights the high responsibility patients have for their own health and for the own treatment process (DGPPN, 2014).

Notes

For more information on this subject see:

Jim Gottstein's Law Project for Psychiatric Rights (<http://psychrights.org/Research/Legal/AdvanceDirectives/AdvanceDirectives.htm>), especially 'Advance Directives in Various Countries' (<http://psychrights.org/Countries/AdvanceDirectives.htm>).

Peter Lehmann Publishing with a list of Danish, English, French, German and Greek articles on the psychiatric will and other advance directives (www.antipsychiatrieverlag.de/info/pt-uebersicht.htm)

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Kellyan Hostility in Psychiatry and Psychology

Kev Harding

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

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 validation 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 their 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 reconstructed, 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 clinicians 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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Concepts from the Work of David Smail Discussed by Members of Walk and Talk

Members of Walk and Talk including Clive Allen, Giovanni Azzolina, Cyril Coakley, Nicki Evans, Guy Holmes, Ian Russell, Gillian Sathanandan, Gary Stevens & John Upton

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, oversight, 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.

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 ill groups, but rather focus on enabling participants to share experiences and come together with an ultimate aim of not just developing a greater 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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Values, Diversity, and Mental Health: An appeal for reform

Christopher J. Willoughby

SUMMARY: Psy professions tend to stare down a bio-psycho-medical microscope that makes the real world invisible. This paper explores the consequences and some alternatives to that fixation.

KEY WORDS: diversity, mental health, human nature, Psy

The shoe that fits one person pinches another; there is no recipe for living that suits all cases.

Carl Jung

Mental health provision is a mess and in urgent need of reform. This despite the 2011 UK Government policy paper, *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*. Fundamental shortcomings, weaknesses, and inadequacies in provision continue to be ignored: a bystander attitude.

Following Wittgenstein's observation that a philosophical problem is best dealt with by addressing the *root* of the problem, the contention in what follows claims that contraindicated interventions occur because providers possess a deeply flawed understanding of human nature. It is that which denies many service users the specific – and often practical – help they actually need. This is not to say that people do not suffer debilitating states of emotional distress or exhibit behaviour regarded as out-of-the-ordinary and, in some cases, odious and objectionable. These behaviours exist; which for some people fall within the bounds of normal conduct while for others it is abnormal. All of which is informed by psychiatric and psychological knowledge. Professions that spend

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much of their time staring down a bio-psycho-medical microscope that makes the real world invisible.

Psy experts and the exploitation of public trust

Human nature is of immense biopsychosocial complexity revealed in different values and a profusion of outlooks. People are also self-regarding and manoeuvre to secure their self-interest. A tendency played-out in myriad ways, not always consistent with the procrustean expectations of the society on which we each depend.

Psy professionals have little interest in the societal aspect of human behaviour. As occupations captivated by an endogenous view, they seek to correct conduct that does not fall within a socially acceptable definition of 'normal'. Indeed, the refusal of the Psy professions to recognise the true nature of human beings is, to borrow an assertion, 'like the Victorian's embarrassment about sex, only worse: it distorts our science and scholarship, our public discourse, and our day-to-day lives. Logicians tell us that a single contradiction can corrupt a set of statements and allow falsehoods to proliferate through it.'¹ So it is in mental health provision – the naked emperor of the human sciences.

Ignoring over-five decades of evidence taken from science, scholarship and common sense, the *mind*-centric biomedical dogma advanced by the Psy professions is unreliable and consequently blights the life of many service users. But who cares? Not democratic governments who understand better than most that, while ever they retain public trust, misleading information ('spin' and concealment) is an effective form of social control. This is most obviously the case when social regulation is undertaken through medical praxis; NHS mental health duplicity masked by institutions of proven worth: medicine, doctor, nurse, therapy, NICE guidelines, The Royal College of ..., all denote trustworthiness.

Yet when UK governments and mental health professionals exploit public trust in this way, they undermine the very principles they claim to represent. For 'trust is a social good to be protected just as much as the air we breathe or the water we drink. When it is damaged, the community as a whole suffers; and when it is destroyed, societies falter and collapse'².

A great deal of mental health provision represents the application of contentious theories and slippery terminology. Consequently Psy professionals often come to different conclusions when faced with the same presenting difficulty. Slovenly self-serving praxis: wholly unacceptable in any other occupation. If structural engineers adopted the same approach buildings and bridges would be forever falling down, which would be a serious matter. Not so in mental health. The damage done is easily concealed through public and political indifference.

But they agree on one thing. The Psy professions take it as axiomatic that those who come to their attention suffer defects and deficiencies (politely called ‘vulnerabilities’) of various biological and psychological sorts, despite there being no conclusive evidence or general agreement to support this claim. Consequently, misdiagnosis and unnecessary prescribing must surely occur as critics suggest and some service users complain.

This lack of clarity and honesty is most apparent in the slipshod definition of terms in *No Health Without Mental Health*, which says that a mental illness is a mental health problem and a mental health problem is a mental illness³. Circular logic that creates a Kafkaesque nightmare for many service users erroneously categorised with specious conditions from which they can never recover.

Critics of the endogenous view claim that if you want to know what is wrong with someone, look at the world in which they live. Look at their circumstances. Did the glass break because it was too thin and brittle or because it was hit by a stone? Distress invariably originates in the *context* of a person’s life. Therefore, most people referred to mental health services are suffering *socially induced misery*, which is not recognised as such by psychiatrists, clinical psychologists and psychological therapists who *individualise* and *internalise* distress. Consequently, misdiagnosis ensures that people do not receive the specific social and economic help they actually need. Contained in the community on medical authority, no longer suffering a social and economic problem. This is how governments of all political persuasions maintain the *status quo* by exploiting public trust through the abuse of medical power. It’s an old argument, which is a measure of how long the injustice has been sustained. Power abused for decades, littered with broken lives.

Diversity

Ethologists understand that sensitivity to the environment is not a deficiency in an organism. Only human beings are held to be defective when they show the signs of socially induced pain. This is particularly the case where people are exposed to discrimination for being unacceptably different: different in their values; different in their temperament; and different in their outlook. Anyone different risks being drawn into a diagnostic system on the authority of psychiatry and clinical psychology: Big Psy.

Veracity and reliability – secured through a wider reading of the human sciences – gives us an altogether more accurate nuanced picture, which shows considerable diversity amongst human beings – as exists with all species. That is because variation lies at the heart of Darwin’s theory of evolution by natural selection.

The evidence derived from seventy-years of neo-Darwinian research says, you cannot have natural selection without differences from which to select. This applies to *Homo sapiens* as much as it does to any other species. Even identical twins are not exactly alike. Charles Darwin (1859) put it this way in, *The Origin of Species by Means of Natural Selection*:

then, considering the infinite complexity of the relations of all organic beings to each other and to their conditions of life, causing an infinite diversity in structure, constitution, and habits, to be advantageous to them, it would be a most extraordinary fact if no variations had ever occurred useful to each beings own welfare, in the same manner as so many variations have occurred useful to man.⁴

In addition, consider, of the 160,000 to 200,000 years *Homo sapiens* are thought to have existed as a recognised species, over 90% of that time was spent surviving by hunting foraging and scavenging. A tenuous existence that nearly failed. But with recovery and high survival rates human beings began to spread around the world; settling and living in diverse cooperative groups of a few dozen, many of who were extended family members. Contact with outsiders was limited and initially treated with suspicion.

With the introduction of agriculture roughly 10,000 years ago, some people gradually began to live in urban communities, made possible through food surpluses, cultural innovation, specialisation, and growing prosperity for the dominant segments of what was increasingly becoming a society. All of which was set against a backdrop of life threatening events such as high infant mortality, fatal diseases and injuries, poverty for the majority, periods of famine, and violent conflict.

Only since the mid-nineteenth century, a mere 165 years ago, have most people lived in an urban setting we would recognise as truly scientific and modern. In the past life for most people was rural, short, fraught with insecurity, and brutal. Consequently we are, as the evolutionary sciences remind us, space age people but with a stone age brain. *Homo sapiens* evolved to survive and replicate in a world very different from the one a small number of innovative problem-solvers have recently made possible.

In a populace of tens-of-millions of people it is, therefore, hardly surprising that naturally occurring diversity does not always accord with political expectations. Currently in the UK and much of the world, free-market capitalism, which is characterised as being very good at creating prosperity (especially for the favoured few) albeit at the expense of everyone else and the natural environment. Consequently, a person may become the wrong kind of human being for no other reason than that they exhibit characteristics regarded

as unacceptable when set against prescriptive social norms. Scapegoats. Modern-day folk devils. The in-group-out-group bias writ large.

For example, to be shy or lack the motivation to be a celebrity, entrepreneur, or ambitious manager in free-market Britain is to your considerable disadvantage; exacerbated if your identity is not that of a compliant 'human resource' (and even worse, 'human capital'): a fungible item that can be replaced with *something* cheaper. Complain about the emotional and practical impact of discrimination, unemployment, and social deprivation – in other words, being treated as an object rather than a person – and mental health categorisation becomes a hermetic glass cage designed to silence the pain of social exclusion.

As an algorithmic process, natural selection has shaped human conduct over hundreds-of-thousands of years, and continues to do so. While this facilitates our biological adaptation to the environment as a species, it does not always work *culturally* to the advantage of everyone. That is because as a slowly evolving heuristic bricolage nature-nurture system, natural selection produces and retains a range of characteristics across the species, some of which are held to be 'appropriate' by the dominant segments of society while others are not.

On this evidence it would seem that in the great scheme of things, nature and the alpha-types couldn't give a fig about our happiness and well-being. From the perspective of unhurried natural selection in conflict with rapid cultural evolution, the driving force of 'survival of the species' becomes: many of us are physically and culturally expendable.

Whether the person you *happen to be* possesses prized attributes is not something over which any of us has any control. We do not choose to be the person we are, neither are we infinitely malleable on the direction of Psy experts and our superiors. Claims of conscious free will and a capacity for resilient psychotherapeutic adjustment are frequently expedient and hugely overstated. A legacy of Judaeo-Christian theology, Cartesian dualism, and the distorting influence of Big Psy.

Not that behaviour remains fixed. Some people change in remarkable ways; sometimes in a manner that leave them distraught, relieved, or ecstatic. Much to the curiosity of reputable human scientists. And so to insist that because there are occasions when psychological therapy *appears* to benefit some, then this should equally apply to all service users, represents an inferential leap that would defeat even the most gifted logician.

Misleading assumptions of this sort on the part of Big Psy – who are clever enough to know better – are engineered from professional expediencies built on a fallacious partisan understanding of human nature and an unconscionable willingness to abuse their power.

Givens

In addressing the root of the problem in mental health – and despite the intractable difficulties created by current social and economic policy – if we *really* valued people (which current mental health policy does not confirmed by the harm it continues to do), research suggests that health and well-being are grounded on accepting two fundamental and inescapable claims – givens.

The first, already touched upon, is that the mix of traits and competencies we each possess is something of a natural lottery. Therefore, whether the characteristics we each possess are viewed favourably by the society on which we depend is not something we can do much about. As the aphorism has it, you can't make a silk purse out of a sow's ear. And while you can certainly take a horse to water, you can't make it drink as teachers and parents will testify.

So while most people wish to realise their potential through being socially engaged – usually to our mutual benefit – the manner in which that might occur will be contingent on factors over which the individual has little or no control. Lest we forget: human beings are first and foremost *social beings*. We do not fend for ourselves, we depend upon one another.

People invariably have a great deal to offer given the right circumstances. Yet whether a person is thought to have any social value depends on the *Zeitgeist* of the time. It's a sociopolitical judgement, not psychological and certainly not a medical judgement.

Therefore, a realistic evaluation of human behaviour is determined by taking account of *all* the known facts, social values, and the morality and integrity of those making the evaluation. And so to contrive a situation in which people are socially excluded for no other reason than that they are different, displays the moral turpitude of eugenics and the intellectual veracity of phrenology. It's nonsense. And deeply damaging nonsense at that.

So the first given presents us with the ethical question of how to socially assimilate and accommodate people despite apparent differences. This presents those who currently benefit from existing social arrangements (in some cases quite spectacularly) with a particular difficulty based on current competitive individualistic values. Why would you want to engage in social change simply to accommodate people you don't know and of who you may not approve even if you did know them?

In addition, social change that seeks to ethically embrace diversity and social inclusion raises the politically inconvenient question of how to achieve this objective in a country in which the population continues to increase in size. Currently in the UK approaching sixty-four-million and rising. Government already grapples with the demands and tensions of considerable cultural and ethnic diversity. On current misunderstanding and policy errors,

how much diversity can a society tolerate before it descends into rampant chaos?

It's not unreasonable to suggest that the discriminative injustice suffered by many mental health users is the crumbling edge of this growing and largely ignored unstable cliff. That is, the unwillingness of politicians to adopt social and economic policy arrangements that are genuinely inclusive: The Good Society. The principle of which they appear to have abandoned. In an era of business managerialism, social injustice and glaring social inequalities are a 'challenge' to be micro-managed not a problem to be solved.

So, despite the need that people have to be a valued member of society, to be different in a manner unacceptable to current social mores presents government with a conflict and control problem. Which is currently masked through 'compassion' and 'care' by pathologising the anguish of being held to be unacceptably different. An expediency that continues to escalate in more broken lives and episodes of social disruption as the cause of this crippling injustice continues to be concealed by the so-called 'experts' in behaviour – Big Psy.

The second given identifies the meeting of elemental needs that are *vital* for human health and well-being. Besides the obvious survival needs of food, water, shelter, healthcare and so on, people also need to feel *socially valued*. They need to satisfy a sense of belonging and they need to secure a sense of purpose and meaning in life through engaging with others. All of which are met when collectively we value each one of us as the person we happen to be. And not simply through hollow political psychobabble rhetoric, but in the *practical* way we weave people into the fabric of society through access to suitable roles and responsibilities.

Paying lip-service to these givens is shabby and mean-spirited. For politicians to imply that a fair and just society will come about once the economy has recovered is dishonest and deeply cynical. It's a social control lie the marginalised and dispossessed have been living with for far too long. Consistent with the trickle-down economics of the 1980s that never happened as intended, but did work to the advantage of a privileged few. The principle of which persists to this day.

Values: Power-orientated or life-orientated?

The deeply damaging controversy in mental health, therefore, turns on the question of what we value most as a society. Either economic security and prosperity for the favoured (which includes the Psy professions) with all the injustice and anguish that inflicts on others through living in a winner-take-all society. Or the values that say, we *really are* all in this together. Suffering is not his or her problem, it's *our* problem. And the solution to our problem is a life-

orientated society of fairness, justice, and opportunity for all, in which different motivations are accepted not managed and marginalised.

The rejoinder made by those who defend orthodoxy claims that the controversy in mental health is actually one of 'ideology'. The assertion being that critics of current provision are not evidence-based but informed by an entirely left-of-centre sociopolitical persuasion, which is simply untrue. Quality provision, for sure, rests on the values of a sustainable pluralistic society. But it also rests on evidence provided by quality research and scholarship taken from *across the human sciences*; rather than rely on a myopic bio-psycho-medical view.

When we adopt the collective values of *us*, *we* and *our* – which really does mean everyone, not simply those politically expedient entities 'the Country', 'Middle Britain', or 'hard-working families' – most mental health problems are manifestations of structural injustice, a lack of opportunity, and the cruel consequences of ruthless competition, all of which create a destructive environment. Science and scholarship puts this claim beyond reasonable doubt.

So, with the exception of those delinquent power-orientated people for whom no amount of thrills, attention, and prosperity is ever enough, evidence suggests that most people look to adopt a secure stable way of life in accord with circadian rhythms, a valued social role, the support of family, friends, and the social milieu, and dignity, respect, and the acceptance of others: life-orientated people. While ever circumstances permit the meeting of vital needs in a manner acceptable to the person, most mature adults look to adopt a sustainable way of life achieved through a culture of care based on the values of service and ethical businesses.

Conclusion

Human beings are an evolved primate: hierarchical, self-regarding, and ultra-social. These features came about to the survival benefit of *Homo sapiens* while ever people lived in an interdependent cooperative group of one sort or another; diverse groups which reflect the differences that exist amongst people. An innate tendency we call *pluralism*. Yet in a fiercely competitive, impersonal, one-size-fits-all, increasingly homogenous society, these characteristics work to the advantage of many but to the disadvantage of others. Which is not dissimilar to living in a badly run zoo that does not appreciate the significance of diversity, and subsequently fails to grasp the need for suitable environments. The absence of which provokes conduct that is aggressive, fearful, and flordid.

In threatening conditions human beings react in a 'fight or flight' manner. Those who possess the necessary characteristics 'fight' through participation and competing. A gentle reserved sensibility often represents a mismatch between the

person and society. Losers then turn in flight – except you cannot escape from the society on which you depend – by becoming increasingly anxious ‘depressed’ and withdrawn. In effect, a deep sense of suppressed resentment precipitated by not being accepted as the person you happen to be; cheated out of a valued role and harmonious social environment. The natural place for life-orientated people, many of whom are women, although not exclusively so.

Therefore the choice mental health providers face is this: Do they continue to promote and personally benefit from a mental health provision that *creates and perpetuates* as much distress as it may alleviate. Or do they grasp the nettle of propriety and engage in the kind of reform that would be genuinely beneficial to the public and service users – as well as offering the prospect of an infinitely more constructive working life for themselves.

Psychiatry and psychology are powerful tools. And like any powerful tool, whether it is used to benefit people or to do harm will depend on the integrity of the people using them. It therefore follows that reform of provision rests on there emerging a critical mass of Psy professionals who are not hindered by personal and professional self-interest. Which is to say, provision open to a realistic understanding of human nature, unwilling to compromise the Hippocratic injunction: First, do no harm. And having fulfilled these two requirements, then, actively engage in reform.

Endnotes

1. Steven Pinker (2002) *Preface* / ix
2. Sissela Bok (1999 [1978]) pp.26-27
3. HM Government policy paper (2011): *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*. The Glossary, Annex C, p.88.
4. Charles Darwin (1872 [1859]) *The Origin of Species by Means of Natural Selection*. London: Senate, p.102

Glossary

Mental health problem

A phrase used in this strategy as an umbrella term to denote the full range of diagnosable mental illnesses and disorders, including personality disorder. Mental health problems may be more or less common and acute or longer lasting, and may vary in severity. They manifest in different ways at different ages and may present as behavioural problems (for example, in children and young people). Some people object to the use of such terms as ‘mental health

problem' on the grounds that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We recognise these concerns and the stigma attached to mental ill health; however, there is no universally accepted terminology that we can use as an alternative.

Mental illness

A term generally used to refer to more serious mental health problems that often require treatment by specialist services. Such illnesses include depression and anxiety (which may also be referred to as common mental health problems) as well as schizophrenia and bipolar disorder (also sometimes referred to as severe mental illness). Conduct disorder and emotional disorder are the commonest forms of childhood mental illness.

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The Construction of Psychiatric Diagnoses: The case of adult ADHD*

Joanna Moncrieff, Mark Rapley & Sami Timimi

SUMMARY: Psychiatric diagnoses have come to shape the way that people conceive of themselves and their lives. A new diagnosis, adult attention deficit hyperactivity disorder (ADHD), has been strongly promoted by the pharmaceutical industry, but the authors question whether the disorder represents a discrete condition that can be distinguished from ordinary behaviour.

KEY WORDS: Psychiatric diagnosis, adult ADHD, pharmaceutical marketing, psy-industrial complex

Psychiatric diagnosis is notoriously pliable. In recent years new diagnoses such as Social Anxiety Disorder, Premenstrual Dysphoric Disorder and Hypoactive Sexual Desire Disorder have been fashioned and promoted by the pharmaceutical industry (Moynihan & Cassels, 2005; Tiefer, 2006; Koerner, 2002) and older diagnoses such as Melancholia or Neuraesthesia have either withered away or, as in the case of Depression and Bipolar Disorder, have expanded beyond recognition (Healy, 2006). Whereas there was once a stigma attached to having a psychiatric label, since the 1990s, drug company funded publicity, and professionally sponsored disease awareness campaigns, such as the UK's Defeat Depression Campaign or Australia's *beyondblue* initiative, have successfully eroded this for many diagnoses. People now frequently arrive at a doctor's office requesting a particular psychiatric label and its associated drug treatment. That is to say, we have recently seen the development of an entirely new, and historically unprecedented, class of psychiatric diagnoses – like PTSD and Asperger's Syndrome – diagnoses that patients actively want to have.

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One recently fashioned – and increasingly popular – diagnosis is Adult ADHD. Building on the propagation of the childhood condition, over the last few years this diagnosis has also been incorporated, almost unquestioned, into the psychiatric canon. Advocates of the ‘condition’ argue that it is a real but previously unrecognised disorder, that needs to be diagnosed and treated more frequently (Kessler et al., 2006). They argue that the condition can be reliably defined and diagnosed, that it is distinguishable from other conditions, that it predicts significant adverse outcomes, and responds well to stimulant drugs (Asherson et al., 2010). We have argued elsewhere that all these contentions are questionable (Moncrieff & Timimi, 2010), but to date there has been no detailed analysis of the evidence base for the diagnosis.

The practically unchallenged acceptance of Adult ADHD is particularly remarkable because the recommended treatment is medication employing a prohibited class of recreational drugs, namely stimulants. The widespread diversion and illicit use of prescription stimulants has been well documented in the academic literature (Arria et al., 2008) and has been identified as a significant problem by policy makers in some areas of the globe (Government of Western Australia, 2007). The extensive literature on adult ADHD is mostly silent on this issue, however, although supporters of the concept sometimes claim, without citing any factual support, that diversion is not a problem (Moyer, 2005). Notwithstanding these claims, it is likely that recreational drugs have not been so easily obtainable on prescription since the widespread prescription of benzodiazepines in the 1980s. Research with drug users suggests they are well aware of how to use a diagnosis of Adult ADHD to acquire their drug of choice (Schubert et al., 2009).

An alternative approach to understanding the phenomenon of Adult ADHD is to view it as the latest creation of the psy-industrial complex (Rose, 1998), like Premenstrual Dysphoric Disorder and Hypoactive Sexual Desire Disorder, constructed by the pharmaceutical industry to market a particular class of drugs, with the support of sections of the psychiatric profession. Nikolas Rose has described the influence of psychological and psychiatric concepts on how people come to construct their own difficulties and how, more recently, we have been encouraged to view ourselves as ‘neurochemical selves’ (Rose, 2004). He shows how the methodological trappings of science; statistics, experimentation and classification, and the discourse of physical medicine are utilised to construct conceptual frameworks through which people can come to understand and act upon themselves. As he suggests:

the conduct of persons becomes remarkable and intelligible when, as it were, displayed upon a psychological screen, reality becomes ordered

according to a psychological taxonomy, abilities, personalities, attitudes and the like become central to the deliberations and calculations of social authorities and psychological theorists alike (Rose, 1998) (p. 60).

In this sense psychiatric diagnoses like Adult ADHD redefine everyday difficulties, whether they be sadness, anxiety, mood swings or inattentiveness as signs of sickness, as disease or disorder in need of treatment. David Healy has argued that a variety of changing diagnoses have been applied to the pool of 'everyday nerves' over the last few decades, driven primarily by the marketing imperatives of the pharmaceutical industry. Hence the market for 'anti-anxiety' medication, the benzodiazepines, was transformed in the early 1990s after the scandals that erupted around benzodiazepine dependence, into a market for 'antidepressants', by the popularisation of a new and broader concept of depression (Healy, 2004). More recently, as many antidepressants have come off patent and atypical antipsychotics have become commercial blockbusters, depression itself has been transformed into a newly expanded concept of bipolar disorder, driven again by disease awareness campaigns run by drug companies (Healy, 2006). The modern notion of depression was itself fashioned alongside the introduction of the first drugs that were labelled as 'antidepressants' in the 1950s and 1960s (Moncrieff, 2008).

Increasing numbers of women are being diagnosed with adult ADHD, and in many countries women outnumber men (Castle et al., 2007), despite the fact that the diagnosis of childhood ADHD is strongly associated with being a boy (Timimi, 2005). Much promotional material now targets women, and suggests that adult ADHD may be the latest framework offered to women through which to express their distress and dissatisfaction (Usher, 1991). However, advocates have argued that ADHD is merely under-recognised in girls (Staller & Faraone, 2006; McGee & Feehan, 1991).

In contrast to the presentation of benzodiazepines as non-specific 'tranquilisers', the marketing of the new antidepressants of the 1990s was based on the idea that depression was caused by a chemical imbalance that drugs could help to rectify. Rose has argued that the popular acceptance of this message has fundamentally altered the way people think about the nature of being human (Rose, 2004). Being human is, under this conception, to be little more than our brain chemicals and hence, in theory, we can use drugs to adjust or rectify our neurochemical state to achieve an ideal level of functioning.

Like schizophrenia, depression and bipolar disorder, adult ADHD is presented in the dominant psychiatric literatures as a neurodevelopmental or neurobiological disorder that responds in a specific way to a particular type of chemical treatment. Because that treatment is a recreational (and presently

illicit) drug, adult ADHD not only has the potential to transform the way we think about various everyday experiences, like forgetfulness, but also to simultaneously normalise and mystify the use of psychoactive substances. The official ratification of the existence of Adult ADHD is then potentially transformative of our understanding of how people use recreational substances, including caffeine and nicotine, for example, and turns the ordinary human inclination for substance use into a medical treatment for an underlying disease.

Here we argue that, in contrast to the notion that it is a recently discovered pre-existing disease, adult ADHD is better understood (*pace* Rose), as one of a number of recent constructs, devised to market a particular class of pharmaceuticals that has started to shape the way in which people think and talk about themselves and their experiences. In order to support our case we examine the evidence base for adult ADHD, to see whether it supports the disease-based concept of adult ADHD as a specific disorder, a disease in the sense of a condition that can be clearly distinguished from other conditions, that has a predictable and homogenous course and outcome, and that responds to specific treatment. Finally, we examine the implications of the popularisation of a disease concept that is linked to the prescription of prohibited substances.

The rise of adult ADHD

In recent years ADHD has been diagnosed with increasing frequency in adults as well as children. Although adult ADHD is conceptualised as a continuation of childhood symptoms, the diagnosis is increasingly being applied to adults who were never diagnosed as children and prevalence studies estimate that between 5% and 9% of the adult population may suffer from the disorder at any one time (Kessler et al., 2006) (Simon et al., 2009). Whereas ten years ago, adult ADHD was a little known and rarely used diagnosis, it is now the focus of increasing academic attention (Figure 1.) and *soi disant* experts are urging that more should be done to identify and treat people with the diagnosis (Kessler et al., 2006). In Europe, the United States and the United Kingdom, special 'adult ADHD' services have been set up to provide specialist diagnostic assessments and treatment, to raise awareness of the condition and screen various populations for its presence (Edwin & McDonald, 2007). Many clinical guidelines, including the United Kingdom's recently published National Institute for Health and Clinical Excellence (NICE) guidelines, have endorsed the disorder and recommended treatment with stimulant drugs (National Institute for Clinical Excellence, 2008). NICE have recently produced a commissioning guide to help local health organisations obtain funding for and set up further adult ADHD services (National Institute for Health and Clinical Excellence, 2010).

Parallel with the acceptance of the diagnosis of adult ADHD, there has been a phenomenal rise in the prescription of stimulants, and related drugs, which has been particularly marked in certain parts of the world including the United States, the United Kingdom and Australia. Dexamphetamine prescriptions dispensed to children in Western Australia, for example, increased by 2400 percent, and those for methylphenidate by 620 percent between 1991 and 1998 (Mackay & Kopras, 2001). Data from England show that overall prescriptions for stimulants increased by more than 500 thousand between 1998 and 2008, an increase of 235%, with costs increasing over ten times (Information Centre for Health and Social Care, 2009; Information Centre for Health and Social Care, 1999). In the United States, prescriptions of stimulants issued to adults alone doubled between 2000 and 2005 (Castle et al., 2007).

The pharmaceutical industry appears to have been instrumental in the rise of adult ADHD and associated prescribing. Pharmaceutical marketing companies have explicitly identified Adult ADHD as an 'expanding and lucrative market' for stimulants and related drugs (Lead Discovery, 2004). Several companies have run direct to consumer advertising campaigns in the United States, which market the disorder by suggesting that common behaviours (such as forgetting car keys) may be symptoms (Food and Drug Administration, 2005). Company websites also contain screening questionnaires that encourage people to seek help if they think they have the diagnosis. Moreover, it has been revealed that some of the researchers who most vigorously promoted the concept of adult ADHD, and conducted many of the drug trials, failed to disclose millions of dollars of income they had received from pharmaceutical companies (Harris & Carey, 2008).

Many studies report higher rates of adult ADHD in women than men, in contrast to the situation in children where boys outnumber girls by a factor of 4 (BUPA, 10 A.D.) The growth in stimulant prescriptions has also been far larger in women (Castle et al., 2007) and educational and promotional material aimed at women is burgeoning. The health.com website, run by Integrated Solutions, a company that offers 'smart, strategic advertising opportunities' to its clients prominently features up-to-date medical information on topics such as *Celebrities Living With Adult ADHD* and describes adult ADHD to women as 'a neurobehavioural condition marked by poor memory, the inability to concentrate on important tasks, and tendency to fidget and daydream, among other symptoms.' The website encourages women to consider the diagnosis by describing how symptoms may be 'more subtle and easily missed' in women (health.com, 2010). *ADDITUDE* magazine's website, a commercially sponsored magazine for sufferers of ADHD, also worries that 'Too often ADD women and girls go undiagnosed and untreated' and carries an article to help them 'learn how to recognise symptoms and get help' (Connolly, 2010).

The validity of adult ADHD

The reason that Adult ADHD is so appealing to drug companies can be readily deduced from both the official diagnostic criteria that are said to define it and the ‘symptoms’ contained in commercially available ‘do-it-yourself’ checklists (see for example *Quiz: Do You Have Adult ADHD?* at the health.com website: <http://www.health.com/health/gallery/0,,20343014,00.html>). All lists of proposed symptoms of adult ADHD contain multiple experiences and behaviours that are nigh on human universals, including forgetfulness, lack of organisation, a tendency to delay important tasks, to be distracted by noise, difficulty waiting to take a turn, irritability and so on. Box 1 shows the *NHS Choices* website’s diagnostic criteria, which are similar to other lists of criteria, including the criteria for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2010). The latter provide numerous examples of the behaviour that might qualify as symptoms, including failing to pay attention to detail, difficulty ‘remaining focused during lectures, conversations or reading lengthy writings,’ showing reluctance to engage in ‘homework ... preparing reports, or reviewing lengthy papers,’ frequently losing objects such as ‘keys, paperwork, eyeglasses or mobile telephones,’ ‘starting tasks without adequate preparation or avoiding reading or listening to instructions’ and ‘impulsively buying items, suddenly quitting a job, or breaking up with a friend’.

It is not clear why such diverse phenomena should be grouped together, and it is clear that the overdetermined, inclusive and general nature of the symptoms allows many problems that might have been given a different diagnosis, or none, to be re-interpreted as constituting adult ADHD. Although the *DSM-5* proposals specified that ‘There must be clear evidence that the symptoms interfere with or reduce the quality of social, academic, or occupational functioning’ (American Psychiatric Association, 2010), it is difficult to think of circumstances in which someone seeking help would not fulfil, or believe they fulfil, this criterion.

Moreover, it is unclear how adult ADHD relates to the childhood condition, since there appears to be a consensus that people with adult ADHD have a different spectrum of symptoms from children supposedly afflicted with the same disorder. Suggested features of adult ADHD include numerous aspects of mental functioning and behaviour that are not even examined in children including lability of mood, irritability, stress intolerance, anger and risk taking and, in contrast to the childhood condition specifications of adult ADHD place little emphasis on hyperactivity. Some commonly used assessment scales for adults include whole new domains such as ‘problems with self concept’ (Conners et al., 1999), and some exclude hyperactivity altogether (Brown, 1996).

Since adult ADHD is thought to involve lower levels of the core features of childhood ADHD and the presence of different symptoms, there seems to be little basis for concluding that childhood and adult ADHD are the same disorder. The NICE guideline endorsed the concept of adult ADHD on the basis of the *absence* of consistent evidence of a difference between childhood and adult ADHD in terms of symptom profiles, rather than any positive evidence suggesting similar symptoms in adults and children (National Institute for Clinical Excellence, 2008).

The well-documented rates of 'co-morbidity' in people diagnosed with adult ADHD confirm the difficulty of viewing adult ADHD as a discrete disorder. In the North American National Comorbidity Survey, 38% of adults diagnosed as having ADHD also fulfilled criteria for a mood disorder, 47% for an anxiety disorder, 15% had a substance abuse disorder and 20% were diagnosed as having intermittent explosive disorder (Kessler et al., 2006). Another study found that 87% of adults diagnosed with ADHD had at least one other psychiatric diagnosis, and 56% had two (McGough et al., 2005). The recently published NICE guideline noted the overlap with various personality disorders, including antisocial, borderline and emotionally unstable personality disorders as well as depression, anxiety and the modern conceptions of bipolar and bipolar spectrum disorder (National Institute for Clinical Excellence, 2008).

Other aspects of the validity of adult ADHD have not been adequately addressed. It has not been established for example, that the so called symptoms reliably cluster together or that they predict specific patterns of impairment and outcome. Even the enthusiasts admit that the course and developmental trajectory of the 'disorder' is hugely heterogeneous (Asherson et al., 2007). It is not surprising that some research suggests that symptoms of adult ADHD are associated with reduced academic, work and driving performance (de Graaf et al., 2008; Fried et al., 2006; Biederman et al., 2006), since the diagnostic criteria themselves describe various difficulties in functioning. The diagnosis is therefore another example of the tautological nature of psychiatric diagnoses (Pilgrim, 2007). The diagnosis is defined by behavioural impairments, but is then said to predict other similar functional difficulties. In addition, the research on associated impairments of adult ADHD has not adequately controlled for the impact of the numerous co-occurring conditions and problems. Evidence from structural and functional brain studies and genetic associations is also cited to support the validity of the diagnosis (Asherson et al., 2010). These studies have been extensively critiqued elsewhere (Timimi et al., 2009), but there are anyway very few studies involving adults.

Drug treatment

The strongest claim that adult ADHD has to validity as a neurobiologically-based brain disease is the contention that it responds specifically to stimulant medication. Low dose stimulants are recognised to produce short-term behavioural alterations including increased attention and reduced activity in animals and normal humans (only at higher doses, like those used recreationally, do they start to increase activity) (Arnsten, 2006), but the evidence that they have any worthwhile, sustained benefits, or any specific effects in people with ADHD is weak.

Studies in children show that stimulants can improve attention and reduce activity levels in the short-term, but these effects are not sustained on long-term follow up, where no difference has been found between drug treatment and treatment with other methods (Jensen et al., 2007). No impact on quality of life or academic performance has been consistently demonstrated either and NICE guidelines recommended restricting stimulant use to children with the most severe symptoms, or those in whom other treatments have failed (National Institute for Clinical Excellence, 2008).

In adults, however, NICE recommended stimulants as a first line of treatment in all diagnosed cases. This recommendation was based on three randomised controlled trials, two of which were conducted by the Harvard group, recently revealed to have substantial conflicts of interests. The third was a small cross over study involving forty five subjects. In contrast, a recent meta-analysis of a larger group of methylphenidate studies found that there was no significant difference between the drug and placebo in parallel group studies (Koesters et al., 2008). In addition, results were substantially influenced by studies conducted by the Harvard group, which reported considerably larger effect sizes than other studies, and increased heterogeneity. The authors of the meta-analysis also noted several methodological deficiencies of the studies as a whole, including the fact that the integrity of the double blind was only tested in one study, in which all the participants could correctly identify which tablet they were taking (Gualtieri et al., 1985). In addition, the longest trial included lasted only 14 weeks.

More recently, a further large parallel group trial has been conducted by Janssen-Cilag, makers of the long-acting preparation of methylphenidate known as Concerta (Medori et al., 2008). A six month trial of the stimulant-like drug atomoxetine, conducted by the Harvard group and colleagues, has also been published (Adler et al., 2008). The Janssen trial, which lasted for five weeks, reported a modest difference in favour of methylphenidate. Reductions in the 54-point Conners' Adult ADHD rating scale scores differed by 3 to 6 points between drug-treated and placebo-treated subjects.

The only longer term data come from the randomised, placebo-controlled trial of atomoxetine, which involved 410 patients (Adler et al., 2008). This study

found no difference between atomoxetine and placebo on its primary measure of work productivity at six months, and found no difference in overall ADHD-related quality of life. One out of four sub-scores of the quality of life rating scale showed a significant difference between drug and placebo at six months, and one out of four symptom measures. However, the absolute difference in change scores on the 54-point symptom scale was only 1.6 points, a difference that is unlikely to have clinical significance. There were no differences on other outcomes which included the Clinical Global Impressions (CGI) scale and Driving Behaviour Survey scores.

The moral to the medical, and back again

The analysis presented here suggests that the validity of the diagnosis of Adult ADHD is questionable, and that the drug treatments that are meant to improve its symptoms have not clearly demonstrated efficacy. The concept does not fulfil any conventionally accepted medical criteria of a disorder or a disease, in that it is not easily distinguishable from 'normality', there is a large overlap with other conditions, outcome is heterogeneous and there is little evidence that drug treatment is specific or effective. Moreover, there is such a discrepancy between childhood and Adult ADHD, with a mismatch in symptoms, and a different gender profile, that makes it difficult to conclude that there is any relation – other than in nomenclature – between the childhood 'condition', and the proposed condition of adults.

In a recent editorial in the *British Journal of Psychiatry*, Asherson, *et al*, suggest that:

ADHD symptoms start early in life ... and are persistent and non-episodic. They are therefore more trait-like than symptom-like, since there is no clear change from a premorbid state, and can therefore be mistaken for character traits that may be deemed resistant to psychopharmacological intervention ... Many adults with ADHD have other problems: antisocial personality, alcohol misuse, substance dependence, dysthymia, cyclothymia, anxiety disorders and general and specific learning difficulties. Early-onset and persistent antisocial behaviour is a particularly common association that sometimes leads to persistent impulsive antisocial behaviour in adult life ... ADHD comes first and may then lead to development of antisocial behaviour, a trajectory thought to be mediated by prominent shared environmental influences ((Asherson *et al.*, 2007) (p. 5).

This quotation illustrates the moralism that many critics have long argued is actually constitutive of the professional psy project *tout court* (Sarbin & Mancuso, 1980; Szasz, 1970). Asherson *et al*'s suggestion that the manifestations of adult

ADHD may be more 'trait-like,' indicates the overlap with concepts such as personality disorder, and indeed, many people who receive a diagnosis of adult ADHD may previously have been given a diagnosis of personality disorder, or be said to have abnormal 'personality traits'. Personality disorder has its origins as a way of medicalising 'immoral' conduct (Rimke & Hunt, 2002) and current criteria for the various personality disorders continue to be strongly imbued with moral judgments about culturally acceptable and appropriate behaviour (Bourne, 2010). Although proponents present adult ADHD within a much firmer disease framework, moral judgements are as intrinsic to its conception as they are to that of personality disorder. The criteria for ADHD concern the failure to achieve an implicitly desirable level of social functioning, and occasionally make reference to the sorts of positively bad or foolish behaviour that sufferers may exhibit. Thus the proposed *DSM-5* criteria offered as an example of symptoms of 'hyperactivity and impulsivity' the suggestion that adults with ADHD 'may commit to a relationship after only a brief acquaintance or take a job or enter into a business arrangement without doing due diligence' (American Psychiatric Association, 2010). On this reading, Asherson *et al's* (2007) assertion that ADHD symptoms predate antisocial behaviour, but that they arise from the same influences, suggests that the two sets of behaviours are simply manifestations of the same problem, namely behaviour that is not ideally suited to the requirements of modern capitalist society. ADHD in children has been said to indicate a lack of the docility required for modern schooling (Timimi, 2005), and in the same vein, adult ADHD appears to describe behaviour that fails to conform to economic demands for competitiveness and efficiency and the ideals of bourgeois morality.

Others have started to document the way that the diagnosis of childhood ADHD has come to shape common perceptions about childhood behaviour and how to respond to it (Timimi, 2005; Graham, 2005). Adult ADHD has no less potential to reshape how society views adult experiences and behaviours and how we perceive the use of substances that impact on behaviour. Just as the newly expanded concept of bipolar disorder places mood change at the forefront of people's awareness (Healy, 2006), so adult ADHD encourages people to conceive of their behaviour through the lens of 'attentional deficits.' The link with drug treatment reinforces the notion that we are 'neurochemical selves' in need of pharmaceutical rectification (Rose, 2004). Similarly, the use of recreational substances that might temporarily increase arousal and attention, is transformed into the notion of a medical treatment with the consequence that the user is no longer required to have a responsible relationship with the substance they consume, only to follow the doctor's instructions.

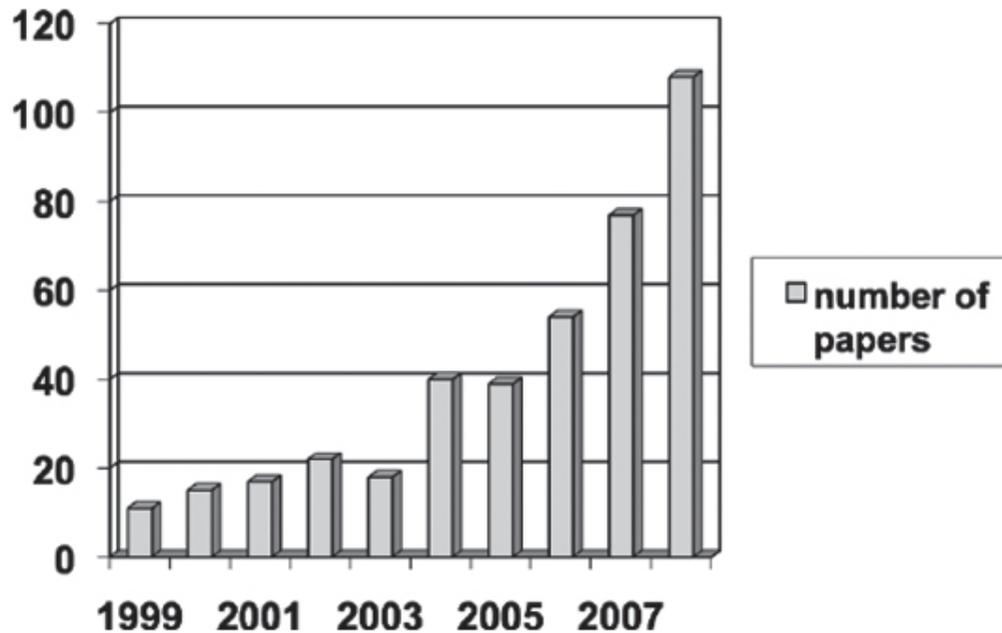


Figure 1: Number of papers published on adult ADHD in Medline since 1999 (retrieved using search terms 'adult ADHD', 'adult attention deficit disorder' and 'adult attention deficit hyperactivity disorder')

Below is a list of symptoms that may be used to recognise adult ADHD:

- carelessness and lack of attention to detail
- continually starting new tasks before finishing old ones
- poor organisational skills
- inability to focus or prioritise
- continually losing or misplacing things
- forgetfulness
- restlessness and edginess
- difficulty keeping quiet and speaking out of turn
- blurting responses, and poor social timing when talking to others
- often interrupting others
- mood swings
- irritability and a quick temper
- inability to deal with stress
- extreme impatience
- taking risks in activities, often with little or no regard for personal safety or the safety of others

Box 1: Criteria listed on NHS choices website.

Available from: <http://www.nhs.uk/Conditions/Attention-deficit-hyperactivity-disorder/Pages/Symptoms.aspx>

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Obituary

Leonard Roy Frank (1932–2015)

Leonard Roy Frank, a psychiatric survivor and activist in the patients' rights movement, was a beacon to psychiatric survivors. In 1962, he was committed to a psychiatric hospital after being diagnosed as 'paranoid schizophrenic' and given 50 insulin coma treatments and 35 ECT treatments. Later, he was on the staff of *Madness Network News*, a publication that was of great value in the early survivors' movement. In December 1973, he and Wade Hudson founded the Network Against Psychiatric Assault (NAPA), a patients' and survivors' advocacy group. That was an inspiration for the formation of MindFreedom. Leonard wrote multiple books such as *Webster's Quotationary*. His most famous book, *The History of Shock Treatment*, published in 1978, is the most detailed history of how and why ECT came to be; a must read for anyone interested in ECT. In it, he presents a completely documented history of this particular form of psychiatric assault. The Preface includes:

'Psychiatrists have written thousands of articles and books recording and purporting to explain the nature, techniques, and effects of shock treatment, and why and under what circumstances it is used. Most of these writings appear in professional journals and reflect a positive attitude toward the procedure. Someone reading them would get little sense of its seriously disabling effects and the horror and outrage experienced by many who have been shocked. Nor would it be apparent from these materials that there has emerged a small but growing number of professional and lay people who are highly critical of the procedure on moral, legal, and medical grounds.'

I met Leonard Frank at the second conference of the old International Centre for the Study of Psychiatry and Psychology formed in the early 1990s by Peter

Breggin; now the International Society for Ethical Psychiatry and Psychology. He was a guest speaker. When he got up and was introduced, he was a striking gentleman who was tall, thin, and angular with a long full beard down to his waist. He probably could have passed for John the Baptist. He was a powerful speaker and in his description of the 50 insulin shocks he underwent and the 35 ECT zaps he received, all I could think of was the time I was hit by lightning in Viet Nam, how that felt, and how this man was standing there in front of me talking about it. I have never cried listening to a lecture, but I sure did that time. A lot of us who knew him will miss him and his courage. Rest in peace Leonard.

Lloyd Ross

Book Reviews

Group and Team Coaching: The essential guide

Christine Thornton

Routledge 2010, £16.99

ISBN: 978-0-415472-28-9

The objective of this book is to provide a new perspective on the subconscious and non-verbal processes through which people learn and communicate with each other in groups. It also aims to provide practical advice about how to accomplish group and team coaching. The question is whether the author, Christine Thornton achieves this. The book is structured in an accessible manner. The book chapters are divided into four parts: The introduction (part one); Principles of group life (part two); The organizational context of groups (part three); Current applications of group coaching (part four). Each of the eleven chapters starts with an overview of the main content headings and the author reinforces understanding and practical applications through the use of boxes with examples and vignettes. The author briefly draws on psychodynamic and systems theory in order to provide an underlying basis to group processes.

Each chapter concludes with final remarks so as to reinforce the key learning points.

I think Thornton achieves her objectives of covering the essentials of group and team coaching. The writing style is clear and would make a good basic introduction to someone who is looking for an introduction to group and team coaching. In my view part five is most useful where the author provides strategies for dealing with problem behaviour in groups. The book may not be suitable for more experienced clinicians as they will already be familiar with psychodynamic and systems theory and how this applies to group processes. Thornton does not provide references with latest research evidence throughout the text although there is a useful references and bibliography section at the end. Hence the book is ideally suited for someone requiring a broad overview of group processes concluding with further guidance for more in-depth reading.

Aafke Ninteman

Principles of Social Change*Leonard A. Jason*

Oxford University Press, 2013, £27.50

ISBN: 978-0-199841-85-1

and

**Parenting and Substance Abuse:
Developmental approaches to
intervention***N. E. Suchman, M. Pajulo & L.C. Mayes (Eds.)*

Oxford University Press, 2013, £60.00

ISBN: 978-0-199743-10-0

Principles of Social Change is comprehensive and well written. Leonard Jason uses personal experiences, stories, and anecdotes to discuss and explore five key principles of how he believes social change can be achieved and cultivated. These principles are: (1) determine the nature of the change desired, (2) identify who holds the power, (3) create coalitions, (4) be patient but persistent, and (5) measure your success. Jason explores each principle in detail and brings them to life with real world examples.

The book focuses on three areas to which the author has invested a life time's engagement and commitment; tobacco prevention – Jason focuses on the reduction and enforcement in the accessibility of illegal tobacco to young people, chronic fatigue syndrome – Jason's work targeted the inaccurate estimates of the prevalence of chronic fatigue syndrome and associated stigma and misnaming. He advocates further research and recognition of the syndrome, and, third, Oxford

House, a community based structured program aiming to reintegrate into the community people who have struggled with substance abuse.

Principles of Social Change is an interesting read and captures the importance of thinking and working in a creative socially aware and community way to accomplish social change and to address social injustice. The book will be of interest to a variety of readers including students, policy makers, psychologists, and social workers.

Suchman et al's timely volume is a well written, thoughtful, and useful contribution to the field of parenting and substance abuse. The book is thought provoking and a useful refresher and reminder of the significance of understanding and responding to parents who use substances. It also has extended relevance to areas of pregnancy, parenting, relational trauma, and child protection. It is a helpful and interesting resource for students, researchers, clinicians and other related professionals. It usefully explores the overlap and interface between two complex multilayered areas: parenting and substance abuse.

It is well structured and draws on the up-to-date evidence base, existing literature, clinical observations, and leading experts. The book successfully combines detailing and exploring conceptual frameworks, the evidence base, theoretical underpinnings, and therapeutic interventions. The book covers both the impact and

consequences of substance abuse on parenting, as well as reporting on relevant assessment, evaluation, and interventions. Each chapter is short and concise ending with helpful reference lists and clinical implications. Various approaches for understanding the use and impact of substance abuse on parenting are explored including psychodynamic, developmental, genetic, cognitive, attachment, and behavioural perspectives. Furthermore a broad spectrum of intervention options are covered: psychoanalytic attachment orientated group interventions, mentalization approaches, interventions for fathers, working with young and adolescent mothers and prenatal interventions.

Karen Treisman

**Voices from the Field:
Defining moments in counsellor and
therapist development**

*M. Trotter-Mathison, J.M. Koch, S. Sanger
& T.M. Skovholt (Eds.)*

Routledge, 2010, £17.00
ISBN: 978-0-415995-75-7

and

**Dissemination and Implementation
of Evidence-Based Psychological
Interventions**

Edited by K. McHugh & D.H. Barlow

Oxford University Press, 2012, £35.00
ISBN: 978-0-195389-05-0

Voices from the Field is a collection of personal stories from various practitioners. These stories describe 'defining moments' which have influenced the author's work within the counselling profession. Each chapter is dedicated to one of the phases of counsellor development as introduced by Ronnestad and Skovholt, from the Lay Helper Phase to the Senior Professional Phase.

The editors provide an easy to read explanation of the aims of the book and tips on how the reader can get the most out of reading it. Each chapter begins with an introduction explaining the respective phase of counsellor development, setting the scene for the stories that follow, and ends with a summary of points for the reader to consider. The questions for the reader at the end of each chapter help to interpret the stories and consider similar themes within their own personal experiences.

A lot of the terminology was particularly aimed towards an American reader with reference to the American pathway into the profession. However, once past the specifics, a lot of the ideas and the overall foundation of the book were transferable to a wider population.

Overall the book makes for inspiring reading, with some of the stories more inspiring than others. The layout of the chapters spans from before the decision to work within the profession, through to the more experienced practitioner. Therefore, this emphasises the importance of reflection throughout the career and highlights the ever-

evolving nature of the profession. There is a real variety of stories which indicate the importance of personal as well as professional experiences and the importance of both positive and negative experiences on our own development.

The overall objectives for McHugh and Barlow's edited volume include describing the current profile and considerations for the future regarding disseminating and implementing evidence based practice into mainstream mental health services.

It is split into two sections. The first section is a general discussion regarding the background and context to dissemination and implementation and identifies concerns with the 'research-practice gap', as well as some difficulties and criticisms of using evidence based methods to inform practice. Section one also includes some theory and models of dissemination and implementation along with some practical examples.

In the second section, each chapter, written by various contributors, provides a detailed example of a particular evidence based programme introduced within mental health service. These descriptions include the context and need of the work/service itself, the actual practical implementation, as well as some critique and evaluation.

Although the authors describe the content of the examples used as 'international', they are predominantly examples from the United States, with only a few exceptions. Despite this, and the authors own acknowledgement that it is 'only a small sampling of

efforts', it is an interesting and engaging text which can highlight lesson learnt from previous implementation efforts along with difficulties encountered and successes achieved.

Generally the text is easy to read and interpret. It would be of use for various professionals working at different levels from research itself to service leads. It is certainly a useful introduction to the topic of implementing evidence based approaches into the reality of the healthcare system.

Zoe Rigg

Handbook of Psychotherapy and Religious Diversity

S.P Richards & A.E Bergin (Eds)

American Psychological Association, 2014,
£71.50

ISBN: 978-1-433817-35-9

This is the second edition of a book initially published in 2000 and edited by the same editors as the original, Scott Richards, a counselling psychologist, and Allen Bergin, a clinical psychologist, who report that the first edition was widely read by practitioners and researchers alike.

The authors of this APA publication are all practitioners or academics in clinical or counselling psychology or ministers of religion and this is what gives the book (528 pp) one of its strengths. Each of the 16 chapters examines the practice of psychotherapy

with different faith traditions grouped under the headings of Christianity, Judaism, Islam, Eastern Traditions and Ethnic-Centred Spirituality, are written by psychologists or ministers with direct experience of or a background in that faith.

What did I find helpful? The chapter on Religious Diversity without a doubt, which, in 30 pages, gives an excellent introduction to the history and beliefs of western and eastern traditions, and which I shall be recommending widely.

What did I find less helpful? The fact that this is an unashamedly North American and, therefore, Americocentric book. The facts and statistics, although interesting, all relate to North America and so are less useful to those very many of us working elsewhere. There are omissions too – humanism, scientology, the Society of Friends (Quakerism) and the Unification Church (Moonies) and many others – could and should all have been included, along with a discussion of agnosticism and atheism.

The other major problem that I had with the book was its, at times, over simplistic approach to how one might engage in psychotherapy with someone from a particular faith background. The world is not as cut and tried as this book might suggest.

Jamie Hacker Hughes

The Oxford Handbook of Organizational Climate and Culture

B. Schneider and K.M. Barbara (eds)

Oxford University Press, 2014, £147.50

ISBN: 978-0-19986-07-1

Climate and culture are repeatedly defined in this 730-page tome. Summarily, culture is the patterns of meaning and behaviour in an organisation (the ‘why’) whereas climate is the overall sense of how the organisation is experienced (the ‘what’). That they are seen as indivisible and influence each other is an enduring theme of the book.

Most readers would engage with this book as a reference rather than a comprehensive read-through and the book is well organised to facilitate that approach. It focuses on micro- and macro- processes in organisations, conceptual and methodological issues, and work-ing in the field as a practitioner or consultant. Within any section the chapters varied hugely in terms of whether they were rich in findings (e.g., West et al on healthcare) or mainly just posed research questions (e.g., Howard-Grenville et al on sustainability). In that the handbook forms part of a library aiming to reflect the ‘dynamism of psychology’ this variability is inevitable. However it also means that the book probably serves best in providing the context for more recent work. I could find no references for example to those people that I understand to be at the vanguard of thinking on organisations such as Laloux or Scharmer. Nor were popular interventions such as

Appreciative Inquiry even touched upon.

Much of the book is illuminating, such as the complex relationship between incentives and performance, and the importance of leaders in establishing identity, modelling values and creating ethical environments.

It will be of interest to many public sector employees that informal, self-management strategies increase engagement and are more productive than formal, structured and bureaucratic methods, and that positive cultures inculcate resilience among staff and lead to productive outcomes, whereas negative affective cultures foster deviant and unproductive behaviour. In this context it is unsurprising that culture change is most effective when individuals and groups display a readiness to change which is in turn influenced by whether individuals perceive that the organisation values human relations.

Altogether though, although the book is aimed at graduate and post-graduate students, researchers and practitioners, I felt it served an academic audience best, giving a snapshot of current progress and future research directions.

Steve Onyett

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Scharmer, C. O., & Kaufer, K. (2013) *Leading from the Emerging Future: From ego-system to eco-system economies*. BK Books.

Books Received

Readers wishing to review these, or any other books, are encouraged to contact the Joint Book Review Editor – Anne Cooke, Clinical Psychology Training, Salomons, David Salomons Estate, Broomhill Rd., Southborough, Tunbridge Wells, Kent, TN3 0TG. Please note; reviewers keep any volume they review. It is appreciated if reviews are received within two weeks of receipt of the book. Reviewers will be sent a subscription form for the journal.

- Burack, J. et al (Eds) *The Oxford Handbook of Intellectual Disability and Development*. OUP.
- Conyne, R. *The Oxford Handbook of Group Counselling*. OUP.
- Dvoskin, J. & Kane, A. *Evaluation for Personal Injury Claims*. OUP.
- Duke, N. & Mallette, M. *Literacy Research Methodologies (2nd Ed.)* Guilford.
- Franklin, C. et al (Eds.) *Solution-Focused Brief Therapy*. OUP.
- Grant, J., Donahue, C. & Odlaug, B. *Treating Impulse Control Disorders*. OUP.
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