Beyond dualism and defamation: utility and action

A more interesting question than ‘where does the truth lie?’ is to ask what are the implications for persons and society of the respective positions of Szasz1 and Shorter.2 Even respected nosologists, explicitly acknowledged in the American Psychiatric Association’s Research Agenda for DSM-5, have abandoned the quest of establishing nosological validity (on the basis of the failure of even modified Feighner criteria) for most psychiatric ‘disorders’, but instead are asking questions about the utility of different diagnostic criteria.3 Therefore, if Szasz is right and mental illness is a metaphor, the Shorter camp might productively ask ‘is it a useful metaphor?’ instead of reverting to a wholly outdated mind–body dualism.

Functional brain imaging reflects lived mental states, and particular brain areas may ‘light up’ in response to a person’s interaction with others and their environment, without necessarily implying neurological causality. Even structural brain changes can in fact imply interpersonal and environmental causality, as the neuroimaging exploring the impact of childhood maltreatment makes clear.4 And ‘difference’ of course does not automatically imply ‘disease’, as the neurodiversity movement has so eloquently argued.5 Individual mental phenomena can be simultaneously described at multiple theoretical levels – from neural networks and psychological descriptions through to narrative, meaning and conscious experience – with bidirectional influence between levels. How neuropsychological processes are recursively embedded within wider social processes is more complex still, although social looping theory is a useful starting point here.6 The ability, however, to hold multiple levels of description in mind often breaks down when meaning is translated into action. The belief that the ‘voices in my head’ are due to a progressive neurological disease as opposed to a disgruntled ancestor or spirit has almost irreconcilable consequences for action. The first signifies a need for medical treatment, presumably medication, the second perhaps a need for dialogue or appeasement with the ancestor/spirit (or, within our contemporary psychologised cultural milieu, perhaps dialogue and integration with this voice/’split-off self part’). Members of the Hearing Voices Network would hold to whatever appears useful.7 New meanings may themselves influence psychological and associated neurological processes reinforced by social looping.6 Medication can only be reconciled with the ancestor/spirit metaphor as ‘something that might take the edge of my distress’ while engaging with this process of restitution, although not all voice-hearers find this acceptable or necessary.7

Szasz questioned the implications for individual agency and personal responsibility of attributing difficult or criminal behaviour to illness. Even if we are not prepared to accept this position indiscriminately, for those already given a diagnosis we can be challenged to ask where the boundary lies between illness and illness behaviour, and personal responsibility of attributing difficult or criminal behaviour to illness. Even if we are not prepared to accept this position indiscriminately, for those already given a diagnosis we can be challenged to ask where the boundary lies between illness and illness behaviour.

There is therefore a real scientific debate to be had. The Research Agenda for DSM-5 proposes empirically testing the utility of different diagnostic criteria for the ‘mental disorders’.3 This evaluation process could be expanded beyond diagnosis to testing out the utility of wider non-diagnostic formulations (where used as an alternative rather than an addition to diagnosis) and linked interventions, on short- and longer-term outcomes (provided that outcome measures reflect what is meaningful to patients/clients, rather than being merely symptom based). Increasing numbers of practitioners are now challenging the value of diagnosis-based systems (see www.causes.com/causes/615071-no-more-psychiatric-labels/about). Evaluating such different modes of practice lends itself to real science, rather than to the moral defamation resorted to by Shorter in his assertion that critically minded practitioners are responsible for, and indiffernet about, countless suicides.

Where is the evidence that the massive worldwide increase in antidepressant prescribing has had a significant impact on suicide reduction?

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Removal of experts immunity

The papers by Thompson1 and Rix2 provide useful information for anyone thinking of entering the field of medico-legal work. Anyone in this position will also want to be aware that earlier on this year, in Jones v. Kaney,3 the Supreme Court decided by a majority of 5 to 2 to remove the immunity that expert witnesses have previously enjoyed. It is too early to say how this is going to affect such work.

I have provided independent reports for solicitors for some years and I think that I have learnt as much from this clinically as anything else I have done. Now more than ever, though, I think it is essential that anyone carrying out such work obtains proper training, carries adequate insurance and pays attention to specific CPD for this, including joining a CPD peer group that can monitor this work and provide helpful support.

Medico-legal work is interesting and challenging, but it does require sound foundations.
The psychiatrist as expert witness

Thompson¹ and Rix² make particularly interesting statements regarding continuing professional education in the area of providing expert reports. I generally agree with the requirements listed by Thompson, with the exception of expecting the psychiatrist to have had specific training in being an expert witness. It seems to me that, although advice about conduct in court is prudent, the requirement of specific training is redundant. The competence and expertise of the witness should rapidly become apparent to the court during the process of giving evidence and being cross-examined.

The testing of a witness’s competence is strictly a matter for the court. Indeed, one of the attractions of my medico-legal work over the past 40 years has been that my knowledge and competence are examined in a very rigorous manner by counsel in the course of giving evidence. I would be concerned if our own professional body were to suggest that an answer in court that one had met the accepted requirements of training as a witness were to replace this.

If the courts were to need such support from our College, it would imply that the general level of competence at the Bar is insufficient and our colleagues at the Inns of Court may need to reconsider their training. For ourselves, our expertise resides in psychiatry with an understanding of the law, not being experts at the law.

Psychiatric reports: a must for all psychiatrists

Thompson’s article¹ about preparing psychiatric reports for courts contains some useful advice, but we were left wondering why she had taken the time to write it, given that she suggests such reticence in taking on this work.

Criminal and other courts rely on psychiatric evidence on occasion and, at least in the UK jurisdiction, where dual loyalties to the court and to the patient are tolerated,² a report for a criminal court is often best prepared by the psychiatrist who knows the patient and will be treating them. Sometimes, for that very reason, a psychiatrist will prefer not to be involved in a court case, but equally, there are cases where they really should be involved, because they will be carrying out the treatment that sentencing might support or enable.

It may be better for a consultant who does not do such work regularly to seek supervision from a more experienced colleague, rather than simply refuse to provide it, as Thompson suggests. There are many other situations in which courts need expert psychiatric evidence, either to meet statutory requirements or on higher court guidance. It is essential that there is a body of psychiatrists available that is willing and able to provide this, and there is no reason why it should come, as Thompson implies, exclusively from the ranks of forensic psychiatrists or clinicians who do not work for the NHS.

Training then becomes crucial, and Rix³ has – much more encouragingly – discussed some of the ways in which it can be acquired. However, he does not address some of the associated matters that Thompson rightly raises. In particular, matters of probity relating to payment for work done and the interface between providing fee-paying services (category 2 work, as it was) and one’s contractual NHS duties are important, and perhaps are not given the explicit attention in training and supervision that they deserve.

In the West Midlands we have prepared explicit guidelines for forensic trainees who are required to engage in this work. This covers matters such as the requirements for supervision and how best to acknowledge this within the report, the arrangements agreed with local employing trusts in relation to office support, guidance on providing estimates of costs and on what aspects of the work are chargeable, the requirements of Part 33 of the Criminal Procedure Rules 2010, and issues of consent, confidentiality and information governance. Although some of these matters are complex and may encompass some variety of practice, the principles are generally clear enough and need to be established openly.

In particular, when preparing a court report, a series of aims or outcomes may be conflated, including the (in category 2 terms) primary outcome of assisting a third party (the court) to meet its objectives (by dealing with the case justly), but also including preparing for the assessment and treatment of the patient in hospital (category 1 work as was), and personal learning and development for the clinician. The amount of time charged for should properly reflect this. Dealing with money may be sensitive, but a trainee’s court report work must be explicitly supervised in terms of probity as well as clinical quality.

We agree with Rix that it would be a shame if psychiatrists were put off gaining competencies in this potentially rewarding, but also necessary, area of work. Many of Thompson’s concerns can be successfully addressed by a more open attitude to the complex probity issues that are involved, rather than simply deciding ‘not to undertake this work at all’.

Declaration of interest

Both authors have provided expert reports for the courts in criminal proceedings of varying degrees of seriousness and complexity.

¹ Thompson AE. ‘You are instructed to prepare a report . . . ‘: How to make sound decisions about whether to accept or decline medico-legal work. Psychiatrist 2011; 35: 269–72.


Mephedrone as a cognitive enhancer and its kinship to khat

The report on the adverse effects of mephedrone in patients presenting to an acute service in Scotland echoed many of our own findings in attendees of a service aimed at the early detection of psychotic illness based in inner-city London.1 In a small sample, we found that 8% of patients (n = 5) seeking help for concerns about their mental health were using mephedrone. They reported using the drug for recreational reasons (during activities such as clubbing) and simply out of curiosity. Four out of the five patients stated that they also used mephedrone as a cognitive and performance enhancer to aid them in their studying and to help them stay awake while at university or college. They explained that it was a cheap and accessible alternative to other stimulants: one dose of 200 mg costs £2–3.

As mephedrone has now been classified as an illicit substance, it is possible that similar (currently unclassified) chemical compounds will become more widely used as cognitive enhancers in the student population. Both acute secondary and primary care mental health services should be aware of the adverse effects of this group of stimulants.

It is interesting to note that mephedrone is a semi-synthetic form of cathinone, the drug found in the East African herb khat. The chewing of khat has a long history and the drug continues to be used legally within several immigrant populations in Britain. Understanding the adverse effects of mephedrone has allowed us to appreciate the adverse consequences of khat misuse—a problem that has provoked substantial debate previously.2


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If not now, when . . . ?

The contrast between the cover of the August issue of The Psychiatrist and the content of the related article1 could hardly have been greater. On the outside: shocking depiction of a winged Freud in drag—women’s bathing costume, high heels—flanked by the sphinx. Inside: announcement of change of job title from ‘consultant psychotherapist’ to ‘consultant medical psychotherapist’, buttressed by bland reassurance that ‘the working role of most medical psychotherapists has become more like that of other consultant psychiatrists’ and that warfare between different therapeutic modalities has ceased, and predictable pleas for greater recognition and investment in medical psychotherapy.

Sadly, it’s the cover that gets it right. Medical psychotherapy is a chimera trying awkwardly to reconcile two currently incompatible sets of values—medical instrumentalism and psychotherapeutic humanism. A change of name will do nothing to resolve medical psychotherapy’s abiding dilemma: how to stay true to psychotherapeutic values without isolationism or, claiming a spot in the mainstream, undermining its case for a separate identity.

I would like to see medical psychotherapy accepting the full irony and challenge of its chimeral status: a ‘hopeful monster’,2 ensuring on the one hand that psychiatry does not become increasingly confined to pharmacology and forensics, and on the other that psychotherapists keep sight of their prime task—contributing to the effective treatment of psychological illness.

But nature abhors a chimera. Cash-strapped chief executives are unlikely to fall in with medical psychotherapy’s vague promises when they can get NICE-approved therapies delivered by bureaucracy-savvy clinical psychologists and nurse specialists at half the price.

Which brings us back to Mace & Healy’s seemingly proud statement that medical psychotherapy is unique among the CCT-bearing specialties in being ‘not descriptive of the types of patients seen’. But therein lies its great weakness. Despite today’s name-change, the rose will smell as uncompelling until the Faculty of Medical Psychotherapy becomes the Faculty of Personality Disorders and Complex Cases. Then at last the unique skills of the medical psychotherapist really will be seen as indispensable, and Mace & Healy’s legacy come to fruition. Yesterday’s hopeful monster may yet become tomorrow’s role-model: the psychotherapeutically sensitive psychiatrist.


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Psychological therapies for bipolar disorder: addressing some misunderstandings

We would like to reply to the letter published in your journal by Gupta & Brown,3 concerning a recent British Psychological Society report on understanding bipolar disorder.4 As authors of that report, we were pleased that it has generated debate. In the main, responses from psychiatric and other clinical colleagues have been overwhelmingly positive: MDF The Bipolar Organisation referred to the report as ‘ground-breaking’4 and Stephen Fry’s tweet on the report led to 2000 downloads in one day.


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We thank Drs Gupta and Brown for their interest in this report, and for giving their opinion. However, they make some criticisms that we feel are based on misunderstandings, and we would like to correct these. In contrast to the view of Gupta & Brown, the report does not present an antipsychiatry position: its explicit purpose is to provide a psychological perspective to supplement the existing literature, which is predominantly based on a biological perspective. The report does discuss the limitations of formal mental health diagnoses, but recognition of these limitations is not discipline specific. In our experience, individuals who have been told they have bipolar disorder are rarely informed about the explanatory and predictive limitations of this diagnosis. By outlining these in our report, we aim to raise awareness that the construct of diagnosis is a subject of debate, and therefore that it may be legitimate to explore alternative means of understanding experiences that are classified in this way. Gupta & Brown propose that diagnoses in mental health are based on specific scientific data about aetiology. We would contest this. Indeed, this is even explicitly spelled out in DSM-IV-TR,\(^4\) which states that recent versions of the DSM ‘attempt to be neutral with respect to theories of aetiology’ (p. xxvi). The authors claim that we do not offer an alternative to diagnostic systems. This is not the case with regard to either the descriptive or the explanatory function of diagnoses. As regards the former, we propose that normal English is sufficient (for example, the report uses ‘a tendency to experience extremes of mood’) and avoids some of the more unhelpful side-effects of psychiatric diagnosis such as stigma. As regards the latter, we propose that this is in any case limited and that individualised multifactorial formulation, where professional and service user work together to identify the various factors contributing to the problem, offers a more useful approach.

We do not claim that bipolar disorder is a lifestyle choice and we do not argue that psychological interventions alone are a preferred solution for all individuals with a diagnosis of bipolar disorder. We do, however, argue (consistent with NICE guidelines\(^5\)) that more people should have access to psychological interventions and that these can improve outcome for some people. Systematic reviews support the benefits of structured psychological approaches, particularly in relation to reduction of relapse risk.\(^6,7\) We do not argue against the use of medication treatments, but we do discuss the fact that they are not necessarily helpful for everyone and that choice in relation to this, as well as other forms of treatment, is an important consideration. We accept that the evidence for psychological interventions is based mainly on participants who are currently receiving medication as well. This could mean that the sole ingredient offered by psychological interventions is an increase in adherence, but this is no more proven than other possible explanations. Indeed, Lam and colleagues\(^8,9\) found significant benefits of cognitive–behavioural therapy for bipolar disorder after controlling for medication adherence. Gupta & Brown are right to point out that there are no drug-free studies of psychological interventions in bipolar disorder. Such studies prove an enormous challenge, given the present readiness to prescribe. However, it is encouraging that psychological therapies appear to be superior to medication in the long term for a range of other psychiatric disorders, including unipolar depression, post-traumatic stress disorder and panic disorder.\(^10,11\) Nevertheless, our approach sees a key role for medication in services, particularly in situations of acute risk, and for clients for whom the benefits are clear. The authors correctly note that we omitted reference to trials by Scott et al\(^12\) (which had negative results) and Miklowitz et al\(^13\) (which had positive results). This we will address when the report is updated, but it does not significantly change the conclusions of the report (nor did it affect the NICE guideline recommendations on psychological therapy\(^14\)). The authors suggest that the evidence informing the report is limited. We disagree. In addition to the trials and experimental research that is covered, we provide extensive reports from large numbers of people with bipolar disorder, reporting on how they have learned to cope with their mood swings. We regard such evidence as primary rather than secondary in the pursuit of a scientific understanding of emotion regulation and how it becomes a problem for many people, just as early psychiatrists utilised a phenomenological stance in building their initial categorisations of mental illness. We welcome the opening of a debate on these issues and look forward to further constructive discussions.

**Declaration of interest**

All six authors are also authors of the report that is the topic of this letter.

The private sector v. the NHS: who’s the good, the bad and the ugly?

For psychiatrists who care for National Health Service (NHS) patients in the private and voluntary sectors, it can sometimes be dispiriting when colleagues make inclusive overtures, but manage at the same time to vent their spleen about the independent sector. Alistair Stewart, in the September lead correspondence item in *The Psychiatrist*, admits that there is ‘the good, the bad and the ugly’ in all sectors, and even that there are ‘flagship private sector providers’, but only lists recent quality failures linked to the activities of private equity groups. He would want to eschew the term independent sector in another NHS psychiatric colleague’s, giving an unbalanced view, preferring frankness such as ‘the private sector milking the money which most taxpayers think is going to the NHS’. Are independent charitable providers and all well-meaning professionals outside the NHS to be tarred with the same brush?

Similarly, in response to an editorial I co-authored, another NHS psychiatric colleague gives an unbalanced view, focusing on fraud in US healthcare, the profit motive and sharp practice, contrasting this with the NHS, which is apparently an example of ‘a system based on trust and common purpose’. Is the truth not that in-house NHS services across the country include both shining examples of excellence and dedication, and scandalous failures of care and management – just as much or as little as many other kinds of organisation?

It is important to see that all sectors have been caught up in the same economic cycle. In the boom years the for-profit, commercial sector brought major investment in modern hospitals and community homes, from which NHS mental health patients have greatly benefited. Many would otherwise be homeless or in prison. The ultimate source of this commercial investment is mostly the savings of ordinary people, funnelled through investment funds of various sorts. Of course this was boosted by irresponsible borrowing, leading now to an intense resource squeeze, to unacceptable quality failures, and to investors making substantial losses.

All this parallels huge government investment in health services in recent years, the consequent public debt, and now severe reductions in spending, especially in social care. Mental health patients are among the vulnerable people affected, as care providers, including many community mental health charities, struggle to survive. Charities have to learn lessons from and compete with state and commercial provision, despite being challenged by the downturn through little fault of their own.

I would encourage NHS colleagues to acknowledge good work done by psychiatrists and mental health workers in every sector, in the best interests of patients, and balance their critical comments with examples of poor clinical practice wherever they arise. It is painful to see the fallout of the international debt crisis roll through our society and affect the most vulnerable. The responsibility rests perhaps with key decision makers in international public and private finance, but let us not become so conflicted that we waste our energies blaming each other in the mental health world.

Declaration of interest

St Andrew’s is the UK’s largest provider of charity sector services to the NHS.

A response to Professor Sugarman

Professor Sugarman’s response to my letter in the September issue helps to clarify a number of points.

First, to deal with sentimental matters. I am sure that all well-meaning professionals outside and inside the NHS have honourable motives and are committed to their patients. However, this is not the real issue. We do not live in the ‘mental health world’ but in a world where the future of the NHS is being threatened by large private sector organisations keen to promote and benefit from certain policy changes. These, in the guise of promoting ‘choice’, will enable them to take large bites out of the NHS and establish the profit motive as the dominant force in healthcare in the UK, just as it already is in the USA. These organisations have been frustrated for a long time by the fact that the existence of the NHS in Britain has restricted opportunities for them. Emails made public this summer, sent by David Worskett, head of the amusingly named NHS Partners Network (representing groups such as UnitedHealth, Care UK, BUPA, the General Healthcare Group and Ramsay Health Care UK), demonstrate the determination of these companies to establish their bridgehead into the NHS.

Professor Sugarman says that the NHS is ‘apparently [my emphasis] an example of a system based on trust and common purpose’. He may well find that very large numbers of people working in the NHS and using it see it in exactly that way, for all its failings.

Professor Sugarman seems keen in his letter to distinguish ‘independent charitable providers’ from the ‘for-profit, commercial sector’. However, in the article he wrote with Professor Andrew Kakabadse in *International Psychiatry*, he appears quite ready to argue on behalf of ‘providers with international experience’ and ‘the power of globalisation of markets and information’ to promote ‘improved care through choice for patients’. Is this how the charitable sector sees itself?

There are signs that some leaders of the charitable sector are smoothing the way for private sector organisations. The
role of the Association of Chief Executives of Voluntary Organisations, and its Chief Executive Sir Stephen Bubb, has been challenged by John Pugh, Liberal Democrat spokesman on health, who said:

‘Asking Sir Stephen to sum up on competition rules is as neutral as asking Simon Cowell to tell us about the merits of TV talent shows. The real problem, though, is Sir Stephen’s enthusiasm for better access to NHS work for the charitable sector, which will be a Trojan horse that will allow huge private companies to dismember the NHS in a chaotic fashion’. 3

How many people working in the charitable sector really want to identify themselves with an organisation such as United Health, which according to its own website has worldwide assets worth US$63 billion? 4

Professor Sugarman is right to draw attention to the fallout of the international debt crisis. The problems of the British economy may be due partly to debts accrued by increased investment in health services. They are much more due, in the UK, to the fact that as taxpayers we have been obliged to spend billions of pounds to prop up the banks, all because the international financial industry had pursued the profit motive to a particularly insane conclusion. It seems a perverse logic to suggest putting the future of the NHS into the hands of organisations driven by these kinds of considerations, and disgraceful to be recommending to people in less well off countries that they should do the same.

The organisations represented by Independent Healthcare Forum attended a conference earlier this month at which they were assured by Lord Howe, a health minister, that there are ‘huge’ opportunities for them to advance their interests in the NHS. 5 Professor Sugarman was a speaker at the same meeting. He may object to me describing the private sector as ‘milking the money which most taxpayers think is going to the NHS’, but the vision of private health companies being offered the tasty prospect of even larger profits by taking over more of the NHS suggests another farmyard metaphor.

5 Beckford M. NHS reforms present ‘huge opportunities’ for private companies, says minister. Telegraph 2011; 7 September (http://www.telegraph.co.uk/health/healthnews/8747701/NHS-reforms-present-huge-opportunities-for-private-companies-says-minister.html).

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