Hugh Middleton

PSYCHIATRY RECONSIDERED

From Medical Treatment to Supportive Understanding

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From Medical Treatment to Supportive Understanding

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This would not have been possible unaided and in isolation. The support of family and friends has been indispensable, but greatest thanks must go to the many hundreds if not thousands of people I have encountered in my professional life. It is a privilege to have been able to spend time with and alongside so many and so intimately. Books, even this one, can only tell so much, and teachers likewise. The real world in all its messiness and uncertainty has much more to offer, and for a doctor that world is their patients'. This comes with heartfelt gratitude to all who over the years have opened up or put their trust in me, doubted and argued. From you I have learned far more than any book could convey or any teacher wisely share.

Hugh Middleton, Nottingham, December 2014

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Introduction

This book has been written because there is a desperate need for it. Public service psychiatry is a fulfilling and challenging occupation but it is wrought with controversy and contradictions. Quite often what was taught during exhaustive training and acquired through reading and research does not prepare practitioners for the job. The task they face and the skills and training they bring to it often fail to add up. Many of those who encounter mental health services as a 'consumer', or as someone associated with one, frequently find themselves confronted by unclear treatment options or difficulties of access. Medical students encountering psychiatry for the first time and probationary doctors testing out longer-term options sense these tensions. For years this has resulted in problems of recruitment and morale, and psychiatry's poor standing within the family of medical specialties. Whether considered in the context of the UK National Health Service (NHS) or in other jurisdictions this raises difficult questions, and those who have chosen a career in psychiatry deal with them in different ways. Some struggle with why they are there and what they are being asked to do. Some buckle down and get on with the job they are paid to do without asking too many questions. Some use the situation as an entrepreneurial opportunity to develop a prestigious career. Whichever that might be and whether employed in the UK by the publically funded NHS, working in private practice or drawing payments from a medical insurance system, what they all share is that they can only flourish if they work in a climate of trust with their clients. It is difficult to do that if you are not quite sure that what you are being asked to do and what you feel is right are the same thing. For students and doctors in training, this book is an attempt to acknowledge these difficult questions, explain what psychiatry really

is about and suggest how it can be an intellectually satisfying, fulfilling and rewarding career in its own right.

The book is also written with an awareness of psychiatry's clientele. Many are frustrated and dissatisfied. In the UK alone there are some 300 mental health service user advocacy groups. If everyone was happy with everything that was being done there wouldn't be much for even one of them to do. As it is they are all very busy, and the same is the case in other parts of the world. People are puzzled. Many scientific and media sources insist that there is an epidemic of mental illness and yet it remains very difficult to define mental illness. Ask an expert and you get as many different answers and opinions as there are experts to ask. Time and time again psychiatrists encounter people who have come or have been sent to them in search of something neither they nor anyone else can provide. Practitioners frequently find themselves conspiring with white lies, suggesting that they can help because that is what is expected of them even though the gap between what is sought and what is possible is often very wide. For the 'consumer' and their associates this book is an attempt to explain why this happens when it does, and suggest alternatives. Although it is written by a psychiatrist who has been confronted by the limits of psychiatry all too often, it is not an apology. Psychiatry does not function in a vacuum. One could suggest that, as with politicians, society gets the psychiatrists it deserves. However, unlike politicians, psychiatrists are relatively invisible until one is needed, and then it is too late to do anything differently. Most only find out about psychiatry and its shortcomings when their life or circumstances bring them into contact with it. There are many accounts of frustration and dissatisfaction arising from such experiences,[1] but the very fact that these continue to be published reflects poor attention to such issues amongst those who have the power to effect change

[1] One of the reasons for this book is a need to respond to the recent surge in publications and other expressions of discontent amongst those who have had unsatisfactory experiences of psychiatry, or sense exploitation amongst those who profit from it. This is a considerable literature that cannot be systematically reviewed here. Seminal contributions include Charles Medawar's and Anita Hardon's *Medicines Out of Control?* (2004), Daniel Carlat's *Unhinged* (2010), Richard Bentall's *Doctoring the Mind* (2009), Jim Read's *Psychiatric Drugs* (2009), Robert Whitaker's *Anatomy of an Epidemic,* Ethan Watters' *Crazy Like Us* (2010), James Davies' *Cracked* (2013) and China Mills' *Decolonizing Global Mental Health* (2014). The concerns raised by these and related contributions cannot be dismissed, and deserve the full attention of those whose tasks it is to make whatever psychiatry is being asked to do work, and work well.

or interest in influencing them. By revealing more of what sits behind psychiatry and why it is so messy and confused, some light might be shone into places where only the vulnerable usually go.

The Scale of Public Service Psychiatry

Most jurisdictions administer mental health services in just the same way as other parts of the healthcare system. During the year 2012/13 there were more than 150,000 admissions to an English psychiatric ward for reasons of one or another form of 'mental disorder'. Of these, about one-third (50,408) were subject to lawful detention under powers of the 1983 Mental Health Act, about two-thirds of them at the time of admission and about a third subsequently.[2] NHS mental health services in England employ the equivalent of some 5,500 full-time psychiatrists. There are some 3,000 in training. Amongst NHS specialists these figures are only exceeded by the numbers of surgeons, of physicians and of anaesthetists. The UK NHS employs around 48,000 psychiatric nurses, 30,000 nonprofessionally qualified mental healthcare assistants, 10,000 clinical psychologists and other professionally qualified therapists, and a significant number of different professionals such as occupational therapists, physiotherapists and pharmacists.[3] Mental health services also enjoy the benefits of joint working with a significant number of social workers employed, in the UK, by local government authorities. Similar per capita figures pertain in other parts of Europe and North America.

One of the reasons for this considerable investment is that mental health difficulties are considered to be very common. Indeed, from some perspectives they are considered to be a public health problem of global proportions. 'No Health without Mental Health' has become something of a campaigning slogan amongst advocates and policy makers.[4] Psychiatric epidemiologists have identified mental illness in around a quarter of the

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[2] The NHS maintains records of hospital admissions, which are available online. These figures were obtained from Hospital Episode Statistics of England, NHS Information Centre, www.hesonline.nhs.uk on 25 June 2014.

[3] Details of NHS staffing are publically available. These figures were obtained from http://www.ic.nhs.uk/pubs/nhsworkforce on 25 June 2014.

[4] The expression was used in 2007 as the title of a paper drawing attention to the global burden of disease attributable to mental health problems (Prince et al., 2007) and in 2011 as the title of a UK government policy document promoting 'esteem between services for people with mental and physical health problems' (Department of Health, 2011).

population in the UK, the USA and Australia,[5] and this rises to 50% if surveys are restricted to those with any reason for attending the doctor.[6] These rates do vary. In 2001–03 the World Health Organization (WHO) conducted an international survey involving 60,463 respondents across six developed and eight less developed countries in Africa, the Americas, Asia, Europe and the Middle East. The highest rates of 26.4% and 20.5% of the population were found in the USA and Ukraine, respectively, and the lowest rates of 4.3% and 4.7% were found in Shanghai and Nigeria (World Mental Health Survey Consortium, 2004). Based upon such figures advocates estimate and draw attention to the contribution mental illnesses make to the global burden of disease. Amongst these, depression is a leading contender. Worldwide, it is currently considered to account for nearly a third of all years lived with disability, and, in this respect, it is expected to become second only to HIV/AIDS by 2030.[7] Current estimates of the burden upon the UK economy stand at over £100 billion per annum, a rise of nearly 30% on comparable estimates made in 2003 and equivalent to more than £1,500 for every man, woman and child in that country. An estimate of the economic cost to the whole of the European Union is €386 billion per annum.[8]

The human cost is illustrated by drawing attention to particular groups that are identified as at heightened risk. Prisoners are especially prone, with one survey reporting 'mental illness' in more than three-quarters of the UK prison population.[9] Only traffic accidents are a more common cause of death than suicide amongst those aged 15–35

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[5] The widely quoted 'one in four of the population will suffer mental illness at some time in their life' is derived from large-scale studies conducted in the 1980s and 1990s, which used structured interviews based upon formal, descriptive diagnostic criteria (Kessler et al., 1994; Jenkins et al., 1997; Andrews et al., 2001; Singleton et al., 2001), an approach to defining cases of mental illness with considerable shortcomings (see Chapter 2).

[6] A survey of patients attending general practice settings in the UK (Kessler et al., 1999).

[7] Mathematical modelling based upon data available in 1990 (Murray and Lopez, 1997) and in 2002 (Mathers and Loncar, 2006) where the burden of disease has been expressed as Disability Adjusted Life Years (DALYS), an estimate of the combined loss of healthy years due to premature death caused by a condition, and the number of years lived but disabled by it.

[8] Economic costs such as these are combined estimates of health and social care costs, losses to the economy due to adverse effects upon people's ability to work and an imputed monetary valuation of the less tangible but crucially important human costs of mental health problems (McDaid, 2008; Centre for Mental Health, 2010).

[9] Face-to-face structured clinical interviews with one in 34 sentenced male prisoners, one in eight remanded male prisoners and one in three female prisoners in England and Wales in 1997 (Singleton et al., 1998).

years, and mental health problems alone are responsible for 35–45% of absenteeism from work.[10] Mental health difficulties result in very high levels of prescribing and associated costs. In the USA, between 2005 and 2008, 3.7% of 12–17-year-olds, 6.1% of 18–39-year-olds and 15.9% 40–59-year-olds were taking an antidepressant, even though less than half of them had consulted a mental health specialist.[11] In the UK the annual rate at which antidepressants have been prescribed rose from around 8 million prescriptions in 1991 to over 50 million prescriptions in 2013.[12]

Tilting at Windmills?

These are all very striking figures. What is even more striking is that despite these facts and figures the medical establishment and governments appear to be relatively unconcerned. If one in four of the population was threatened by an obviously disabling illness such as influenza or diabetes there would be calls for emergency measures. Bulk provision of appropriate treatment would be arranged, preventive measures discussed and healthcare professionals trained up to address the epidemic. As it is, mental health services do not enjoy disproportionately high investment, medical schools continue to limit psychiatry to relatively short undergraduate attachments and, to date, there is no obligation to include experience of psychiatry in primary care practitioner training. Predictably enough this relative marginalisation of psychiatry in general undergraduate medical training is reflected in graduates' career choices. Recent English figures suggest that interest in psychiatry as a career choice amongst recently qualified doctors is falling, even from a fairly low baseline.[13] Similar findings have emerged from surveys

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[10] The Member States in the WHO European Region met at the WHO European Ministerial Conference on Mental Health in Helsinki in January 2005 to 'tackle one of the major threats to the well-being of Europeans: the epidemic of psychosocial distress and mental ill health'. These are two of the many concerns about the socioeconomic costs of mental illness emphasised in that report (The World Health Organization Regional Office for Europe, 2005).

[11] Data from the National Centre for Health Statistics, US Department of Health and Human Services (Pratt et al., 2011).

[12] The NHS Information Centre collates data concerning prescriptions by NHS doctors. These figures were obtained from http://www.ic.nhs.uk/statistics-and-data-collections/primarycare/Prescriptions on 26 May 2014.

[13] The proportion of UK graduates choosing psychiatry was relatively stable at around 3.6% during the last three decades of the twentieth century (Brockington and Mumford, 2002). Expansion in the number of medical graduates in one English region has not been accompanied by a concomitant rise in the number interested in psychiatry (Brown et al., 2009).

conducted in Australia, Canada, the Gulf States, India, Italy, Kenya, Pakistan, Portugal, Saudi Arabia, the USA and the West Indies.[14]

This is not new. In 1959 Sir Dennis Hill gave a paper to the Section of Psychiatry at the Joint Annual Meeting of the British Medical Association and Canadian Medical Association in Edinburgh, in which he expressed concern about recruitment into psychiatry and criticised medical schools for giving insufficient attention to relevant subjects such as psychology and sociology (Hill, 1960). Neither is it resolved, as these more recent surveys clearly demonstrate.

Psychiatry undoubtedly has an image problem that discourages recent graduates and young doctors from making it a career choice, and yet from another perspective mental health problems are presented as a major, global public health issue. On the face of it this is a stark contradiction. Mental health difficulties are said to be common, are becoming more widespread and are making up an increasingly greater contribution to the overall pool of disability. They also make up a considerable proportion of the work of general practitioners and primary care physicians. In contrast, medical schools are unwilling to make a deeper commitment to psychiatric training, and programme tutors are unwilling to oblige general practice and other trainees to include psychiatry in their postgraduate programmes. The recently qualified don't want to do it. This is a conundrum seeking an explanation.

One of the medical student surveys from Australia, one from Canada and one from Scotland give some hints from their explorations of students' reasons for and against making psychiatry their career (Gowans et al., 2009; Curtis-Brown and Eagles, 2011; Mahli et al., 2011). Against were perceptions that psychiatric patients did not get better, and that the speciality lacked a proper scientific basis and was less well respected as a result. In favour were factors that made it attractive to students with an interest in the arts and held a more social orientation. These are not necessarily surprising findings but they do point in an important direction. Psychiatry is unattractive to those who have entered medical school narrowly bent upon applying their scientific skills and training to identify, understand and treat illness. It is attractive to those who have entered medical school following an interest in understanding and helping hurt and disabled people. If medical schools were to be serious about addressing the recruitment crisis faced by psychiatry in the face

[14] In 2008 the World Psychiatric Association launched a three-year action plan (Maj, 2008), and many of these surveys resulted from it. Its first stated priority was to 'enhance the image of psychiatry worldwide'.

of an apparent epidemic of mental illness, then they might be expected to focus more upon nurturing relevant interests and skills. Interestingly, they haven't. These are just the same concerns Sir Denis Hill drew attention to more than half a century ago. To quote from that 1959 address: much of medical education 'would seem almost expressly designed to shield the student from awareness of the patient as an individual' (Hill, 1960, p. 918), and in terms of increasing the proportion of medical graduates interested in psychiatry, nothing appears to have changed.

In fact, it would seem that over the last 50 years the very opposite has happened. Rather than addressing the lowly status of psychiatry and related difficulties of recruitment by emphasising its humanitarian orientation and objectives, a lot of effort has been put into dressing it up as a scientifically based medical speciality. It has proved to be more attractive to brand psychiatry as a modern, scientific medical speciality than acknowledge that this approach may not be fit for purpose. As a result, there are daily news items reporting scientific findings which promise … at some unspecified time in the future … that this, that or another brain scan finding will explain this, that or another form of disturbing behaviour, or that a gene has been identified that may be associated with a particular mental illness. On the front line the expectations and false hopes these claims fuel have to be met by practitioners armed with nothing more than medications that act in ways they don't fully understand, may not be anything other than powerful placebos and that certainly haven't improved in efficacy for 50 years,[15] promises of psychological therapy that are notoriously difficult to fund and provide through anything other than expensive private healthcare insurance schemes, and their raw humanity. It is barely surprising that the public is puzzled and frequently angry, that psychiatrists themselves are divided and that the work isn't generally to the taste of fresh, perceptive young medical graduates seeking a career in what they have been taught to understand medicine to be.

The book will go into a lot more detail about why psychiatrists and those who work with them were misguided in not taking the advice of Sir Denis Hill and others more than half a century ago. It might beguile and enchant some psychiatrists and their associates to be seen as participants in a 'modern medical speciality', but it is clear that medical students and recently qualified doctors, medical school curriculum boards,

[15] These are now widely accepted conclusions. Justifications for them are considered in more detail in Chapters 3 and 4, or by Joanna Moncreiff in *The Myth of the Chemical Cure* (2009).

healthcare planners and funding organisations can all see through the smoke and mirrors. When medical students and young doctors reject psychiatry as a career choice it tends to be because it does not fit the image of a *proper* medical speciality, and when they do embrace it, they do so for exactly the same reason … psychiatry offers a readier opportunity to practice in a patient-centred way than the more scientifically ordered areas of medicine. Furthermore, it isn't just young doctors who recognise how poorly psychiatry fits the mould of *proper* medicine. I was preparing for the UK MRCPsych examination (equivalent to Psychiatry Board Examinations) at the same time that a wedding was on the horizon. 'Well', said the prospective mother-in-law, 'if the examinations don't go well he can always go back to proper medicine'.

Synopsis

In a nutshell, this is what the book has to say. Many, if not most, of the frustrations, contradictions and confusion experienced by practitioners and clientele alike can be traced to the unsuitability of locating provision for people with 'mental health difficulties' alongside other aspects of medical practice and within the institutions they occupy. There are many reasons why this has happened and they will be explored by explaining what contemporary psychiatric practice is and why it is a very blunt tool when set alongside the tasks it is charged to fulfil. Chapter 1 provides a conventional account of how mental health difficulties are classified. For the student and the trainee there is enough detail here to understand the structures of diagnostic schemes they may be obliged to learn. Psychiatry's clientele and the interested third party are provided with an overview of the conditions psychiatry engages with. Chapter 2 reconsiders the implications of these diagnostic schemes. It interrogates the logic behind them and shines a light upon ways in which medical terminology has been appropriated by psychiatry. It concludes that mental health difficulties do not support the use of terms such as 'diagnosis' and 'disease' as they are used in other areas of medicine. Chapter 3 describes the medicines psychiatrists use, rationales behind them and their shortcomings. Again, there is enough authoritative detail here for the student or the trainee seeking to prepare for an exam or for guidance on how to use psychiatric medication. Psychiatry's clientele and the interested third party are provided with information about psychiatric medicines and a description of the haphazard rather than scientific ways in which they have been developed. Chapter 4 looks at drug treatments from a more critical perspective. It discusses some of the

inherent difficulties faced by those who would view psychiatric disorders as abnormalities of brain chemistry susceptible to drug treatments. The point is made that prescribing a medicine is much more than just making a chemical available, and some of the implications of this for the use of psychiatric drugs are discussed. The first part of Chapter 5 provides a description of the psychotherapies, their origins and how they are conceptualised. The second part draws attention to findings that suggest psychotherapies have more in common than distinguishes between them. It concludes by considering a longstanding question … 'Is psychological therapy about specific techniques or just the provision of a helping relationship?'

Chapter 6 picks up the question: 'If psychiatry is not about treating illnesses, then what is it about?' An attempt to answer this is offered by looking at what psychiatrists are expected to do, in the form of what primary care practitioners ask for in a number of representative and clinically credible referral letters. The conclusion has to be that what psychiatry is being asked to do is better understood from a social than from a medical perspective. Diagnostic categories might provide a tidy way of classifying human distress and difficulties but the real world is different and psychiatry is inescapably set in the real world. For the student and the trainee this chapter provides an authentic account of what the public service psychiatrist's work is really all about. For psychiatry's clientele and the interested third party this is intended to draw back the veil that so often comes down when a set of difficulties is referred to 'the professionals', and prompts questions about whether or not 'professional help' is always the best way forward. Chapter 7 sets psychiatry in an historical and sociological context. Psychiatry and its antecedents have always played a part in maintaining social order; at its most obvious, in containing situations where private or public safety might be at risk. To what extent are its wider applications but an extension of this? In general, students and trainee doctors are poorly provided for when it comes to historical and sociological perspectives of medicine. These are of particular importance to a full understanding of psychiatry, and this chapter fills that gap. For the outsider and the client these reflections set the expectations placed upon psychiatry in a wider context, and offer further explanations of why it may not be able to provide all that is asked of it.

This is an honest account of what emerges from more than 20 years' experience in the field, the privilege of being paid to study and comment, and association with numerous equally experienced and like-minded individuals. It takes one to some interesting places. If psychiatry

is not *proper* medicine, then what is it? What is proper medicine and what are its boundaries; what does and what does not distinguish it from other caring enterprises? By what authority does it hold such high esteem amongst them? These raise parallel questions about the nature of mental health difficulties if they are not to be framed as illnesses in the way medicine and wider society frame other conditions. How have we come to speak of a global epidemic of mental illness? If we reject the notion of mental illness as others have, then how should we respond to the realities of human despair, confusion or overwhelming anxiety, and of disturbed individuals behaving in threatening or dangerous ways?[16] Chapter 8 acknowledges and attempts to address some of these questions and their implications for practice. Psychiatry is obliged to engage with whole people and their vicissitudes. Rather than suffering as a poor relation amongst medical specialities constrained to provide priced interventions and packages of care, it can and should be seen as first among equals amongst attempts to reach out towards those whose lives have become burdensome and a source of trouble to themselves and other people.

[16] Possibly the most renowned criticism of a medical approach to mental health difficulties is Thomas Szasz's *The Myth of Mental Illness*, which was first published in 1961. A major criticism of his views, and possibly a reason why they haven't attracted a more influential following, is that he fails to acknowledge the imperative strength of human suffering to drive others to relieve it, whether in a personal capacity, by the provision of professional expertise or as an institutionalised feature of a civilised and compassionate society.

1

International Classification of Diseases Chapter V and Diagnostic and Statistical Manual: Cataloguing Mental Illness

A first step towards understanding contemporary psychiatry is a grasp of how mental illnesses are identified and classified by those whose work is to do so. Classification is fundamental to all forms of scientific enquiry and investigation.[1] Classification is also an essential feature of ordered social life. Without agreed ways of categorising people, their qualities or their actions bureaucracies, labour markets and systems of justice would not function. People have to be defined by age (child, working age or pensioner) and level of employment in order to administer an agreed system of taxation. A person's skills and qualifications have to be identified by some form of classification before a decision can be made about their suitability for a particular occupation, and actions have to be classified as lawful, reprehensible or criminal if they are to be judged appropriately.

Illnesses are classified in a variety of ways. This may be by cause; bacterial or viral meningitis, on the basis of assumed understanding of underlying mechanisms; obstructive or hepatocellular jaundice (respectively, something wrong with the drainage of bile or something wrong with the liver), by appearance; different forms of eczema, or by location

[1] Popper (1965) identifies science as the enquiry of testable predictions. Knowledge develops as a result of falsifications that reveal the shortcomings of pre-existing explanations. Any one falsification can only be an enduring contribution to knowledge if it is replicable. If an observation is to be replicable, then it must be made upon explicitly defined phenomena. Classifications of natural world phenomena such as species of plant or stellar objects provide the definitions whereby an observation can be formally defined and therefore available to replication. A field of enquiry is only susceptible to *scientific* investigation *after* its constituent parts have been subjected to an *agreed* scheme of classification.

in the body; breast, bowel or lung cancer. Each of these routes to classification provides its own information about the similarities and differences between conditions that do or do not fall into the same category. Knowledge of the underlying cause or mechanism can provide useful information about how to proceed with treatment. The appearance of eczematous skin can tell the dermatologist much about prognosis, likely causes and possible reactions to treatment. Where a cancer lies in the body and how far it has spread are powerful determinants of how it might threaten vital organs and even life itself.

In order to make sense of all this information and to allow scientific, therapeutic and epidemiological research various medical bodies have developed widely agreed schemes for classifying illnesses. The most comprehensive of these is the International Classification of Diseases (ICD), which is made up of 20 chapters covering each of 20 sets of medical conditions ranging from 'Infectious and Parasitic Diseases' to 'Injury and Poisoning'. There are two additional chapters that provide classifications of 'Factors Influencing Health Status and Contact with Health Services' and 'Codes for Special Purposes'. The ICD has been through several revisions since it first appeared in 1900.[2] The current ICD classification of mental illnesses is found in Chapter V, 'Mental and Behavioural Disorders' of version 10 (ICD-10; World Health Organization, 1992). At the time of writing ICD-11 was under development.

Recent times have also seen the development of an alternative but very similar classification of mental illnesses overseen by the American Psychiatric Association (APA). The first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) was introduced in 1952. It, too, has been subject to serial revisions, and the current version is

[2] The origins of the ICD are traced to Jacques Bertillon's Classification of Causes of Death, which was introduced to the International Statistical Institute in Chicago in 1893. A first edition of the International Classification of Causes of Death arose from a conference convened in 1900. There were minor revisions until the publication of the sixth edition, ICD-6, in 1948, when it became more comprehensive and the name was changed to the International Statistical Classification of Diseases, Injuries and Causes of Death. ICD-6 was the first edition to include a section concerning mental illnesses. The World Health Organization (WHO) sponsored the seventh and eighth revisions in 1957 and 1968, respectively. ICD-9 was ratified by the WHO in 1975 and ICD-10 in 1990. ICD-10 comprises the facility to code some 155,000 different conditions. ICD-11 is expected to be complete in 2015.

DSM-5, which was published in 2013. Other schemes for classifying mental illnesses include the Chinese Society of Psychiatry's Chinese Classification of Mental Disorders and the Latin American Guide for Psychiatric Diagnosis. Sponsorship by the World Health Organization (WHO) and the APA, respectively, has ensured that ICD Chapter V and the DSM are and remain the most influential. All of these, but most notably ICD Chapter V and the DSM, are essentially catalogues of the many and various forms distressed or distressing human behaviour has been found to take.

As a result of this wide scope ICD-10 Chapter V and DSM-5 are each both complex and comprehensive. ICD defines some 80 distinct mental and behavioural disorders grouped together into ten subchapters or blocks, and provides criteria for even more refined subclassification. This enables more than 700 permutations. DSM-5 identifies 19 sets of disorder based upon common presenting symptoms, typical age at onset and presumed cause (American Psychiatric Association, 2013). Together, these comprise some 140 potentially distinguishable conditions. Many of these are then further subdivided so that this manual offers some 500 possible permutations. ICD-10 might, therefore, identify someone as suffering from schizophrenia as one of the conditions covered in subchapter or block three, 'Schizophrenia, Schizotypal and Delusional Disorders', narrow this down to paranoid schizophrenia as opposed to another of the eight different types of schizophrenia it recognises, and then the person might be further classified on the basis of how their condition is progressing as 'Paranoid Schizophrenia, Episodic Remittent', meaning that they suffer a pattern of repeated episodes of mental state disturbance characteristic of paranoid schizophrenia as opposed to continuous symptoms or symptoms currently in remission. DSM-5 would regard the same person similarly, as suffering 'Schizophrenia'; one of the conditions grouped together under 'Schizophrenia and Other Psychotic Disorders' and then further define them as suffering 'multiple episodes, currently in partial (with inter-episode residual symptoms) or full (without inter-episode residual symptoms) remission' depending upon the course of the condition and their current mental state. Whether it is helpful or distracting to try and classify or catalogue to this level of detail is a debate to return to, but the framework they are based upon does offer a way of classifying and therefore making some sense of what mental disorders are and how they compare and contrast with one another. What follows is a brief guide to

how mental disorders are classified by ICD-10 Chapter V.[3] Similarities and differences with DSM-5 are provided later in the chapter.

Organic Mental Disorders

These are described and defined in the first block or subchapter of ICD-10 Chapter V. They are disturbances of mental state or intellectual capacity believed to be due to potentially identifiable damage to the brain or to neuronal degeneration. Here we find classificatory criteria for different types of dementia: Alzheimer's disease (early or late onset, atypical or mixed type, unspecified or residual category), six forms of vascular dementia,[4] and six forms of dementia arising during the course of another identifiable disease such as Parkinson's disease or HIV. There is a residual category of 'unspecified dementia'. This subchapter also defines organic amnesia not attributable to alcohol or other intoxicants,[5] such as a memory loss after head injury. It refers to four different forms of delirium and to 14 different forms of disturbed mental state such as alterations of mood or hallucinations that could arise as a result of brain damage or physical illness. There is a separate section concerning five possible types of personality and behavioural disorder other than dementia that are considered to be due to brain disease, damage or physical dysfunction.

Substance Misuse

The second subchapter refers to mental and behavioural disorders attributable to the harmful effects of psychoactive substance use: intoxication, dependency, withdrawal and toxicity. It is ordered around the various forms these might take following the misuse of any one of nine

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[3] ICD-10 Chapter V has been published in several forms or as several derivatives, as part of the complete ICD-10 and as *Clinical Descriptions and Diagnostic Guidelines* (the 'Blue Book'), in 1992, as *Diagnostic Criteria for Research* in 1993, as a *Pocket Guide to ICD-10 Classification of Mental and Behavioural Disorders* in 1994, and in the form of *Diagnostic and Management Guidelines for Mental Disorders in Primary Care* in 1996. It has also been used as the basis of structured and digitised schedules for use in surveys and other research, the *Composite International Diagnostic Interview (CIDI)* and the *Schedules for Clinical Assessment in Neuropsychiatry (SCAN)*. This account has been developed with reference to the Blue Book. See First and Pincus (2009).

[4] Degeneration of the brain due to impairments in its blood supply.

[5] Amnesia: memory loss.

identifiable psychoactive substances such as alcohol or cocaine, or a residual category of 'multiple drug use and use of other psychoactive substances'. The harmful effects of any one of these offending substances are identified as one of ten possibilities, such as 'acute intoxication', 'dependence syndrome' or 'amnesic (memory loss) syndrome'. Using this system a person considered addicted to opiates and successfully taking prescribed methadone replacement would be classified as suffering 'Mental and behavioural disorders due to opioids: Dependent syndrome: Currently on a clinically supervised maintenance or replacement regime'. Someone suffering delirium tremens with convulsions following withdrawal from heavy habitual alcohol consumption would be classified as suffering 'Mental and behavioural disorders due to alcohol: Withdrawal state with delirium: With convulsions'.

Schizophrenia, Schizotypal and Delusional Disorders

These form the substance of subchapter three. The most important of these, schizophrenia, is the term that has been used to identify classic 'madness' since early in the twentieth century.[6] The other conditions considered in this subchapter—schizoptypal disorder, delusional disorders, acute or transient psychosis, and schizoaffective disorder—are all conditions that display some but not all of the features of 'full-blown' schizophrenia. 'Full-blown' schizophrenia is associated with the

[6] Records and portrayals of people who are disturbed and disturbing owing to odd beliefs, experiences and views of others date from classical times. Some of the earliest British records are from Bethlem Hospital, or Bedlam, which was established as a place of incarceration in London by the late sixteenth century. The figure of 'madness' is portrayed in the form of Tom O'Bedlam, a popular ballad of the time, and as an alias adopted by Edgar in Shakespeare's *King Lear*. The character of 'Poor Tom' illustrates many of the features of disturbed thinking, victimisation and 'unreal' experiences characteristic of contemporary schizophrenia. The term 'schizophrenia' was first used by Eugen Bleuler in 1908 (Bleuler, 1908). He contested the view of his contemporary, Emil Kraeplin, that the condition was a premature form of dementia (Dementia Praecox) and argued that it reflected the breaking up or splitting of psychic functioning (Fusar-Poli and Politi, 2008). 'Schizophrenia' is derived from the Greek roots, *schizen*, 'to split' and *phren*, 'soul, spirit or mind'. In doing this he identified schizophrenia as a process rather than a distinct condition. However, the importance attributed to this underlying process has waned since the middle of the twentieth century with the adoption of descriptive rather than explanatory approaches to classification and in relation to schizophrenia, focus upon Schneiderian first-rank symptoms.

so-called Schneiderian first-rank symptoms.[7] These form an essential feature of schizophrenia itself, although they are sometimes found, to some degree, in other conditions. They are particular forms of the hallucinations and delusions common to all forms of psychosis and could be considered the more striking forms hallucinations and delusions take. In this context, the term 'hallucination' refers to the convinced experience of one or more voices, sounds, smells, visual imagery, sights, other forms of visual experience or bodily sensations for which there can be no agreed external source. The term 'delusion' refers to a strongly held belief or understanding that others do not share, and which is resistant to debate, argument or persuasion. Religious beliefs are conventionally differentiated from 'delusions' by reference to the fact that others of the same religious tradition will share them.

A disturbed or distressing state of mind might be classified as evidence of schizophrenia if it includes one or more Schneiderian first-rank hallucinations and/or delusions, and it would be confirmed as such if the experiences continued for a month. ICD-10 further subclassifies schizophrenia on the basis of associated features such as prominent concerns about being under surveillance or the victim of a conspiracy (paranoid), prominent disturbances of thoughts and organisation (hebephrenic), posturing or other abnormalities of movement or compliance (catatonic), over-riding social deficits after a longer period of classic symptoms (residual), and undifferentiated or simple.

Schizotypal disorder is identified as a condition characterised by eccentric behaviour, anomalies of thinking and reactions to others, which resemble those found in schizophrenia, but without evidence of the first-rank symptoms that define it. Delusional disorders are conditions in which a person is troubled by one or more persistent convictions, which usually have distressing implications but no grounding in fact. They include

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[7] Kurt Schneider (1887–1967) argued that a central feature of schizophrenia was an inability to establish boundaries between self and not-self. He described a number of ways in which this might express itself in the form of disturbed or disturbing mental experiences: one's own thought spoken aloud, others' voices arguing or conversing (when no one is present), voices commenting on one's actions, the experience of bodily or mental actions being controlled by others or an external agency, thoughts being withdrawn or taken out of one's mind, others' thoughts being inserted into one's mind, one's thought being broadcast in a way that others can experience them, and adopting and holding on to a incongruous conclusion (delusional perception) (Schneider, 1959). Although Schneiderian first-rank symptoms do occur in other conditions, such as profound disturbances of mood and certain forms of drug intoxication and withdrawal, they are considered an essential feature of schizophrenia.

morbid jealousy or Othello Syndrome where, as in Shakespeare's play of that name, someone has become groundlessly convinced of their conjugal partner's infidelity with distressing and sometimes tragic consequences.

Subchapter three also includes criteria and codes for acute and transient psychosis. These are disturbances of mental state that might include features of schizophrenia but which only last for a few days, and are frequently associated with stressful circumstances, and schizoaffective disorders. Schizoaffective disorders are conditions in which the disturbance of mental state includes some of the features of schizophrenia and some of the features of a mood disorder (outlined below), without amounting to grounds for full classification as either.

Given their close association with traditional concerns about 'madness', namely unpredictable and violent behaviour, descent into incompetence and dependency, and the visceral discomfort of witnessing another person tortured by distressing thoughts and experiences, schizophrenia and associated conditions are probably the most notorious of the 'mental illnesses'. As a result, only modestly convincing experiences of 'voices' or unconventional beliefs can raise unwarranted concerns. The presence of voices per se does not mean a person has schizophrenia and even if a condition does meet criteria for classification as 'schizophrenia', that is by no means automatic condemnation to a life of torment and incapacity.

Mood (Affective) Disorders

Subchapter or block four of ICD-10 Chapter V considers conditions in which the predominant disturbance of mental state is undue sadness or undue happiness. A period of undue sadness may be classified as an episode of 'depression'. A period of undue happiness or irritability with others' attempts to dampen high spirits may be classified as a 'hypomanic' episode. The term 'mania' is reserved for more striking presentations of these difficulties, and because of the wide availability of sedating medications, it is now a relative rarity.

As changes in mood are a feature of everyday life, ICD-10 sets out formal criteria that are used to discriminate between 'normal' and 'abnormal' mood states, or signs of a disorder. A period of noticeable happiness or irritability with others' attempts to dampen high spirits would be considered an episode of hypomania if it is considered abnormal for the individual concerned, lasts for at least four days and includes at least three of increased activity or physical restlessness, increased talkativeness, difficulty in concentration or distractibility, decreased need for sleep, increased sexual energy, mild overspending or other types of reckless or

irresponsible behaviour, increased sociability or overfamiliarity. A period of noticeable unhappiness would be considered a mild depressive episode if it has been continuous for two weeks, includes at least two of depressed mood that is definitely abnormal for the individual and present for most of every day uninfluenced by circumstances, loss of interest or pleasure in activities that are normally pleasurable, decreased energy or increased fatigability, and one or two of the following, depending upon whether two or three of the former are present (four symptoms have to be present in total): loss of confidence or self-esteem, unreasonable feelings of self-reproach or excessive and inappropriate guilt, recurrent thoughts of death or suicide, complaints or evidence of diminished ability to think or concentrate, changes in the level of physical activity resulting in agitation or retardation (either subjective or objective), disturbed sleep, and change in appetite (decrease or increase) with a corresponding change in weight. An episode would be considered to be of moderate severity if the total symptom count is six, and severe if all of the first three symptoms are present and the total symptom count is eight.

Criteria for bipolar disorder are the experience of at least one hypomanic (or manic) episode and one or more past episodes of either depression or hypomania. This subchapter also provides criteria for the classification of persistent mood disorders such as cyclothymia, in which there are fluctuations of mood that do not fulfil criteria for episodes of depression or hypomania, and dysthymia, in which there is persistent or episodically low mood that does not fulfil the criteria for depression. Particularly intense disturbances of mood can be associated with disturbed thinking and related psychotic (schizophrenia-like) experiences. As a result, subchapter four identifies some 35 different mood disorders on the basis of whether or not the predominant disturbance of mental state is undue sadness or undue happiness meeting criteria for a depressive or a hypomanic episode, whether or not such episodes are recurrent, their severity and whether or not they are associated with psychotic symptoms. Someone who is currently elated and believes they have special powers that enable them to heal others' illnesses by email, who has been in this state on this occasion for at least four days, has been in a similar state in the past and who has suffered a period of low mood of at least two weeks' duration in between times might be classified as someone with 'Bipolar disorder: Current episode hypomanic: With psychotic symptoms'. Someone who has been unusually and persistently unhappy for at least two weeks, feels tired, has lost confidence, is having difficulty concentrating, is off their food and is having difficulty sleeping, and has been like this before might be classified as someone with 'Recurrent depressive disorder: Current episode moderate'.

Neurotic, Stress-related and Somatoform Disorders

These are described in ICD-10, Chapter V, subchapter five. It refers to conditions in which the predominant disturbances of mental state and behavioural difficulties take the form of undue anxiety, conditions considered directly consequent upon stress and/or trauma, and conditions characterised by undue and persistent worries over health and illness. Anxiety and its big sister, fear, are not in themselves abnormal. Neither is distress following a traumatic experience or worries over health or illness. All of these only become a concern when they restrict life unduly or happen in situations with an intensity that others cannot share. In the same way as it does for mood disorders, ICD provides criteria that can be used to distinguish between 'normal' and 'abnormal' anxiety, fear, distress or concern.

Anxiety comprises behavioural components (a tendency to avoid anxiety-provoking situations, or a search for reassurance and repeated checking), physiological components (raised heart rate, breathlessness, perspiration, light headedness or a dry mouth) and subjective or cognitive components (a preoccupation with the perceived source of danger, selective attention to potential sources of threat and a tendency to jump to untoward conclusions). Thus, when the difficulty is one of disabling unwillingness or difficulty entering certain situations or leaving a place of safety, accompanied by physiological signs of anxiety and an experience of danger, ICD criteria will identify one or more of three phobic disorders: specific phobia, where the feared situation is well defined, such as heights or the company of spiders; agoraphobia, where the feared situation is public spaces; or social phobia, where the concern is with being in a situation where one might be a focus of others' attention. If the difficulty is due to repeated concerns about the possibility of a sudden and life-threatening or seriously disabling illness and the reaction is intense fear and an understandable search for professional help or safety, then ICD will identify it as panic disorder. More continuous and persistent worries about well-being might be classified as generalised anxiety disorder. A condition in which the behavioural and subjective components of anxiety have become more clearly focused upon a search for medical support, reassurance and diagnosis would be identified as one or another of several different subtypes of somatoform disorder. Where the predominant difficulty is an intrusive and at times irresistible urge to act in order to neutralise an unreasonably feared consequence the condition is likely to be classified as obsessive–compulsive disorder. Examples of this might be repeated washing or cleaning in response to unreasonable fears of contamination, or repeated checking

of locks or switches because of unreasonable concerns about risk. In all of these cases, and in common with mood disorders, the main criteria that confer status of 'disorder' upon a condition are duration, intensity and the extent of resulting disruption. It is the form these take that distinguishes one anxiety disorder from another.

The same is also true for ICD criteria that define 'morbid' reactions to severe stress and adjustment. A situation would be classified as an acute stress reaction if difficulties clearly follow, within an hour, upon 'an exceptional mental or physical stressor' and include physiological symptoms such as palpitations or light headedness, and emotional distress such as anger, aggression or despair. Post-traumatic stress disorder is identified when such sequelae persist and are accompanied by intrusive recollections of the stressful event. The term 'adjustment disorder' is used to identify longer-term difficulties following a less exceptional stressor. Adjustment disorder is further subdivided into seven subtypes on the basis of predominant emotional and/or behavioural difficulties. Reactions to stress or other difficulties that have resulted in mental shutdown, loss of memory or the development of disabling but medically unexplained physical health problems such as paralysis or difficulties speaking are termed dissociative or conversion disorders, and the ICD sets criteria for the classification of some 12 subtypes on the basis of the precise form the resulting disability takes.

Behavioural Syndromes Associated with Physiological Disturbances and Physical Factors

Subchapter six provides classifications of several groups of conditions in which there is concern and difficulty in relation to physiological disturbances and physical factors. These include eating disorders, sleep disorders, sexual difficulties, mental and behavioural problems associated with the puerperium,[8] and the abuse of nondependence-producing substances such as laxatives or steroids.

Concerns about body weight and eating would be classified as anorexia nervosa if body weight is 15% or more below what would be expected for that age and height, weight loss is self-induced by the avoidance of 'fatty foods', there is self-perception of being too fat and

[8] Formally the period of six weeks following childbirth but generally extended for somewhat longer.

there is evidence of a hormone disturbance, which in women commonly results in amenorrhoea. Bulimia nervosa is identified where there are similar concerns about weight but the person is commonly of normal weight and suffers alternating episodes of a compulsion to overeat (binge) and desperate attempts to compensate by self-induced vomiting, purging, periods of starvation or the use of appetite-suppressing drugs. In order to qualify there must be a pattern of at least two episodes of overeating per week for at least three months. Altogether, ICD identifies eight subtypes of eating disorder.

Difficulties with sleep include problems getting to sleep, excessive daytime sleepiness a disturbed sleep–wake cycle, sleepwalking, night terrors and nightmares. ICD-10 Chapter V classifies these as mental and behavioural disorders when the condition results in marked personal distress or interferes with everyday living, and there is no evidence of a medical condition such as pain or a troublesome cough that could provide an explanation. In the case of difficulties with sleep, such as problems falling asleep, maintaining sleep or nonrefreshing sleep, criteria are that this must occur at least three times a week for at least three months,. Excessive sleepiness is classified a disorder when there are complaints of excessive daytime sleepiness or sleep attacks, or experience of a prolonged and difficult awakening nearly every day for at least a month. Nightmares are classified a disorder when the person experiences the dream and any related disturbances of sleep as markedly distressing.

Sexual difficulties are classified as mental and behavioural disorders when there is no medical explanation for a lack or loss of sexual desire, lack of sexual enjoyment, impotence, premature ejaculation, vaginal pain on intercourse, vaginal spasm, excessive sexual drive or a set of unspecified sexual difficulties. Paraphilias, or disorders of sexual preference, are classified in subchapter seven (see next section). Broad criteria for any form of sexual dysfunction are that the person is unable to participate in a sexual relationship as he or she would wish, that this difficulty occurs frequently but not necessarily continuously, and that it has been present for at least six months. Excessive sexual drive is not formally defined.

The inclusion of a separate subsection that refers to mental and behavioural disorders associated with the puerperium is a way of identifying mental state disturbances occurring shortly after (within six weeks of) childbirth. Many of the more recognisable forms of this, such as postnatal depression, might fit criteria for a mood disorder, and would then be classified as such. This subsection refers to disturbances of mental

state beginning shortly after childbirth, which may have become a source of concern but which do not fit elsewhere in the classification.

Disorders of Adult Personality and Behaviour

These are the subject matter of ICD-10 Chapter V, subchapter or block seven. These conditions are conceptualised in a different way from those making up the other nine blocks. Rather than being seen as evidence of dysfunction in one or another domain of mental life, such as intellectual capacity, mood, reality appreciation or anxiety, these conditions are conceived of as clinically significant conditions and behaviour patterns that tend to be persistent and are the expression of an individual's characteristic lifestyle and mode of relating to themselves and others. As a result, criteria for classification depend upon the presence of troubling or distressing patterns of behaviour or habits. This block covers 11 different subclasses of adult personality disorder, enduring personality changes due to, for instance, a catastrophic experience, habit and impulse disorders, gender identity disorders and disorders of sexual preference. General criteria for the presence of an adult personality disorder are that there is evidence of characteristic and enduring patterns of inner experience and behaviour that deviate markedly from the cultural norm in terms of ways of perceiving and interpreting, emotional reactions, control over impulses and gratification of needs, or the manner of relating to others and handling interpersonal situations; that such deviations from the norm are pervasive, inflexible and maladaptive over a wide range of personal and social situations; that they are a source of distress or adverse impact upon the social environment; and that they are stable and have been a feature of the person's demeanour since adolescence or early adult life. ICD-10 identifies nine distinct types of adult personality disorder on the basis of forms taken by these deviations from the norm, a mixed and an unspecified classification. The nine distinct forms include dissocial personality disorder, which is similar to the historic notion of psychopathy, and which is distinguished by callous unconcern for the feelings of others, disregard for social norms, rules and obligations, incapacity to maintain enduring relationships, low tolerance of frustration, a limited capacity to experience guilt and a tendency to blame others. Emotionally unstable personality disorder of the borderline type is characterised by disturbances in and uncertainty about self-image and aims, a liability to become involved in intense and unstable relationships, excessive efforts to avoid abandonment, recurrent threats or acts of self-harm and persistent feelings of emptiness. Others include schizoid personality disorder where the predominant

deviation is withdrawal from others and a preference for solitary activities, paranoid personality disorder where the predominant deviation is undue suspiciousness and social distrust, impulsive personality disorder, histrionic (theatrical) personality disorder, anankastic (obsessional) personality disorder, and dependent and anxious personality disorders.

Habit and impulse disorders include pathological gambling, pathological fire setting (pyromania) and pathological stealing (kleptomania). Gambling is defined as pathological when there have been two episodes of gambling over a period of a year that have not had a profitable outcome, that are continued despite personal distress and interference with everyday life, that are associated with an intense urge to gamble, an experience of being unable to stop and a preoccupation with thoughts or mental images that concern gambling. Pyromania and kleptomania are similarly defined and poorly regulated impulses to set fires or steal, respectively. Gender identity disorders are conditions in which an individual expresses and experiences a desire to live or dress as one of the other sex. Disorders of sexual preference are identified when there is experience of recurrently intense sexual urges and fantasies involving unusual objects or activities which the person either acts upon or finds markedly distressing, and which have been persistent for at least six months. Criteria for the classification of paedophilia are that these urges involve an interest in sexual activity with prepubescent children and occur in someone of at least 16 years of age and at least five years older than potential victims.

Mental Retardation

Various forms of mental retardation or intellectual disability are classified in subchapter or block eight. Mild, moderate, severe and profound are distinguished on the basis of IQ:[9] mild is an IQ of between 69 and 50, moderate of between 49 and 35, severe of between 34 and 20 and profound of less than 20, which equates to a mental age of three years.[10] Additional codes are applied to indicate whether or not there

[9] Intelligence Quotient (IQ) is a measure of intelligence derived from performance scores on a standardised scale such as the Wechsler Adult Intelligence Scale normalised around 100 where the 25th and 75th percentiles are 90 and 100, respectively, and represent the average range, and the 90th percentile is 120 above, the scores of which are considered superior.

[10] An estimate of the success with which a child has achieved the level of intellectual development expected of their chronological age. Obtained by comparing abilities measured by standardised tests with results from children of the same and differing ages.

are significant impairments of behaviour requiring additional attention or treatment.

Disorders of Psychological Development

Disorders of psychological development that become apparent during childhood are considered in subchapter nine. Some 20 different syndromes are identified. These include several forms of disordered speech and language development, which together affect more than 5% of children:[11] impairments in the specific development of scholastic skills such as reading, spelling and numeracy, which include dyslexia and acalculia; developmental disorders of motor function such as dyspraxia; and several forms of pervasive developmental disorder, including childhood autism and Asperger's syndrome. Childhood autism is recognised as the occurrence of difficulties in the development of language as a means of social communication, narrowly selective forms of social attachment or impaired development of functional or symbolic play before the age of three years, along with other behavioural and interactional signs of significantly limited social capability. Asperger's syndrome is considered a 'milder' form of autism in which the child shows no deficits of language or other aspects of psychological development before the age of three years but does develop an unusually intense and circumscribed interest, or restrictive, repetitive and stereotyped pattern of behaviour. All of the many disorders of psychological development can be and frequently are associated with behavioural difficulties, problems of school discipline and take their toll upon family life.

Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

Other childhood conditions are considered in block or subchapter ten. These include hyperkinetic disorders, conduct disorders, emotional and mixed disorders of conduct and emotion, phobic and social anxiety

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[11] Of 5–6-year-olds attending kindergarten across three regions of Iowa and Illinois, 7,218 were screened. Of these, 26.2% were found to have some form of language impairment and 7.4% were found to fulfil criteria for specific language impairment: difficulties with language acquisition in the absence of intellectual disability, other forms of developmental delay, or physical impediments to speech or hearing (Tomblin et al., 1997). Earlier surveys had found somewhat lower rates (Fundudis et al., 1979).

disorders of childhood, disorders of social functioning specific to childhood and adolescence, tics and certain other conditions that usually begin early in life or that cause difficulties during later childhood and adolescence such as bed-wetting, stuttering or stammering.

ICD-10 does not explicitly use the term 'attention deficit hyperactivity disorder' or 'ADHD', but the problems attributed to difficulties encapsulated by this term are considered in the classification 'hyperkinetic disorders'. These are defined as conditions that become apparent before the age of seven years and in which there is definite evidence of abnormal inattention; for instance, careless errors in school work or other activities, ready distractibility, or frequent loss of important items such as school books, toys or tools, hyperactivity in the form of fidgeting, inappropriately moving about in the classroom or other situations where keeping still might be expected, noisy play or other forms of excessive movement, and impulsivity such as blurting out answers in class, failing to wait for turns in games or group situations, and interrupting others or talking excessively.

Conduct disorders are conditions in which there is a repetitive and persistent pattern of behaviour that violates the basic rights of others or major age-related social norms, and which has been present for at least six months. Examples of such violations include frequent, severe and age-inappropriate temper tantrums, actively refusing adults' requests, often lying or breaking promises to obtain goods or favours, physical cruelty to other people or animals, frequently truanting before the age of 13 years, and bullying or crime involving intrusion into others' personal space such as mugging or house-breaking. Oppositional defiant disorder is a form of conduct disorder usually identified in younger children and classified on the basis of markedly defiant, disobedient or disruptive behaviour at an age before more clearly delinquent, aggressive or unsocial behaviour is possible.

Emotional disorders with onset in childhood have many similarities with the neurotic disorders of adulthood but they are conceptualised with respect to the part played in healthy emotional development by successful attachment to one or more appropriate parental figures. Separation anxiety disorder is identified when there is an abnormally intense and persistent fear of separation that has arisen in early childhood and that is associated with significant problems of social functioning. Particular features include unrealistic and persistent worry about possible harm befalling parental figures, unrealistic concern that an untoward event such as accident or illness will cause separation, reluctance to go to school or elsewhere because of a reluctance to separate,

difficulties sleeping alone and repeated physical symptoms such as nausea, headache or vomiting when separation is threatened. Mixed disorders of conduct and emotions are identified when there is a combination of features characteristic of conduct and emotional disorder. Phobic disorders of childhood and social anxiety disorder of childhood are identified with features in common with both neurotic disorders of adulthood and separation anxiety disorder in a combination that tends to reflect age. The older the child, the more closely the pattern resembles the form found in adults.

Disorders of social functioning specific to childhood and adolescence also include elective mutism in which there is evidence of normal language development, overall, but difficulties speaking in certain social situations such as school, where speaking would be expected, and forms of attachment disorder that differ in pattern from separation anxiety. Tics are defined as involuntary, rapid, recurrent and nonrhythmic movements or vocalisations that are of sudden onset and serve no apparent purpose. Bedwetting is considered a mental or behavioural disorder when it occurs at least twice a month in children younger than seven years of age or at least monthly in children older than seven, has persisted for at least three months, and cannot be explained on the basis of physical illness or deformities affecting the urinary apparatus, epilepsy or other neurological disease. Stuttering is considered a disorder when there is frequent repetition or prolongation of sounds, syllables or words, or frequent hesitations that cause marked disruption and have been present for at least three months.

DSM-5

To all but the aficionado the classification of mental disorders offered by DSM is indistinguishable from that offered by ICD. In the past, explicit efforts were made to harmonise them in full but these were only partly successful.[12] Nevertheless, both identify essentially the same conditions in very much the same way. Differences are mainly those of how they are grouped. DSM-5 identifies and classifies delirium,

[12] Two meetings were convened during the 1980s in an attempt to harmonise schemes of classification. Kendell (1991) provides an enlightening account of how and why this process was of only limited success. Nevertheless, differences between the schemes of classification are of minor significance outside the worlds of academia and epidemiology (Andrews et al., 1999; First and Pincus, 1999).

dementia and other cognitive disorders in much the same way that ICD-10 classifies organic mental disorders in subchapter one. Similarly, DSM-5 specifies the same range of potential substance-related disorders and defines them on the basis of very much the same criteria used by ICD-10 in subchapter two, and the same is true for schizophrenia, schizotypal, schizoaffective and delusional disorders in ICD-10, subchapter three. DSM-5 separates depression and bipolar disorder into two sections, whereas ICD-10 considers both under 'Mood or Affective Disorders', subchapter four. DSM-5 separates out anxiety disorders, obsessive–compulsive disorders, trauma- and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, and sexual dysfunctions into separate sections, whereas ICD-10 includes all of these in subchapter five, 'Neurotic, Stress-related and Somatoform Disorders'. DSM-5 has separate sections for disorders of feeding and eating, elimination (urination and defecation), and sleep, all of which are considered together by ICD-10 in subchapter six, 'Behavioural Syndromes Associated with Physiological Disturbances and Physical Factors'. Five DSM-5 sections—'Paraphilic Disorders' (disorders of sexual preference), 'Gender Dysphoria', 'Disruptive, Impulse-control', 'Conduct Disorders' and 'Personality Disorders'—cover the conditions described by ICD-10 in subchapter seven, 'Disorders of Adult Personality and Behaviour'. One DSM-5 section, 'Neurodevelopmental Disorders', incorporates the conditions covered by ICD-10 in subchapters eight and nine. DSM-5 makes no specific provision for disorders usually arising in childhood and adolescence, preferring instead for such cases to be considered instances of comparable disorders occurring at any time in life.

Strengths and Shortcomings

It would be a source of great concern and confusion if two highly prestigious bodies, the APA and the WHO, were unable to agree upon a scheme of criteria for classifying 'mental illnesses'. That the ICD and DSM differ only in detail, and agree that the phenomena generally regarded as 'mental illnesses' or 'psychiatric disorders' do conform to certain patterns of behaviour, reported experience and observable disturbances of mental state confirm the fact that the field can be formed into recognisable patterns trained observers can agree upon. As a result, this way of considering the field has provided an almost universally applied approach to classifying or cataloguing distressed or distressing behaviour. Based as it is upon observable criteria generated by empirical research and expert opinion it provides an authoritative set of

statements about what is and what is not a 'mental illness', and which 'mental illness' might be present when one is implicated. ICD and/or DSM criteria provide a framework upon which practitioners, policy makers, investigators and entrepreneurs can all agree as they work within, administer and act upon the world of mental health difficulties. It is a *lingua franca* psychiatrists have to acquire in the course of their training. Clinical trials employ ICD and/or DSM criteria in the course of selecting subjects, and when a new treatment is licensed, the licence refers to the new treatment's use in this or that ICD- and/or DSM-defined condition. Similarly, funding agencies and commissioners agree to reimburse on the basis of whether or not diagnostic criteria have been met and an identifiable condition addressed; and when considering pleas of mitigation, courts of law tend to look for expert opinion that frames the defendant's difficulties in this way. Undoubtedly, the ICD and DSM offer an invaluable administrative service, and they provide a framework for certain forms of empirical research. However, any system of classification is only as good as it is useful in a particular context or valid as a generalisation across contexts.[13] There are justifiable criticisms of the extent to which the ICD/DSM approach to cataloguing 'mental illnesses' offers anything more than support for a set of administrative processes. It does provide a tidy and authoritative way of categorising distressed and distressing people, an otherwise messy and difficult field, but how well does it provide insight into the nature and causes of their distress and inform the efforts of those charged with providing for them? That question is the topic of Chapter 2, which addresses the extent to which the term 'diagnosis' might have been misappropriated by the DSM, and the implications of that if it has indeed happened.

[13] In his Statesman dialogue, Plato discusses the business of grouping objects based upon observable shared properties. Aristotle applied categorisation to the classification of living beings on the basis of perceived similarities. Hacking (2007) has discussed the classification of people, including persons with certain types of 'mental disorder' in these terms and with reference to the influences of context and utility upon how this proceeds.

2
Misunderstandings of 'Diagnosis'

The International Classification of Diseases (ICD) Chapter V and the Diagnostic and Statistical Manual of Mental Disorders (DSM) make use of use two key words. The former is entitled the 'International *Classification* of Diseases' and the latter, the '*Diagnostic* and Statistical Manual'. Within, the text of each makes use of *classification* and *diagnosis* as if they were interchangeable terms. Under careful scrutiny 'classification' and 'diagnosis' are found to mean different things, even though their uses often overlap in medical circles. Many of the difficulties and frustrations associated with psychiatry can be attributed to misunderstandings that originate in failures to be clear, in the clinic, whether a condition is being 'classified' or is being 'diagnosed'.

On the face of it this might appear to be no more than an observation upon word use, or even a transatlantic nuance. However, words convey meaning, and how they are used influences received understanding. That is particularly true when the meanings and understandings in question are of something as poorly understood and as infrequently part of everyday language as mental health difficulties, and the word uses in question come from authoritative sources such as the World Health Organization (WHO) or the American Psychiatric Association (APA). Such authoritative uses of *diagnosis* in place of *classification* can readily convey an impression or implications that might not be justified or even intended. Any account of how mental health difficulties have come to be regarded, identified and provided for has to include consideration of ways in which everyday understanding of them has been shaped by the words used to refer to them. From other perspectives, *classification* and *diagnosis* have quite distinct meanings and implications. A troublesome consequence of using them interchangeably in psychiatry is that these distinctions are glossed over. In order to

understand why this matters it is worth spending a little time reflecting upon what 'classification' and 'diagnosis' mean in a wider context, what *medical diagnosis* actually amounts to, and whether or not this is applicable to the use of ICD Chapter V and DSM-5. There may well be readers who are familiar with this debate, and for whom what follows is a redundant reiteration of familiar material. However, as many of the dissatisfactions with mental health services and other disappointments experienced by those who rely on them can be traced quite clearly to such misunderstandings it is worth labouring. Are mental health difficulties afforded the status of illnesses to be diagnosed and treated by medical psychiatrists because they genuinely deserve that status, or are they afforded that status by conventions arising from the habitual but uncritical use of medical terminology in relation to them? What follows is for those who may not have given serious consideration such a question.

Classification

As a noun, 'classification' can be defined as 'The result of classifying; a systematic distribution, allocation, or arrangement of things in a number of distinct classes, according to shared characteristics or perceived or deduced affinities', and, as a verb, 'The action of classifying or arranging in classes, according to shared characteristics or perceived affinities; assignment to an appropriate class or classes'.[1] The fundamental part classification plays in all forms of study and investigation has already been noted.[2] Classification is a cornerstone of systematic thought, and classifying elements of the natural world—plants, animals, rocks, soils, tides, clouds and other phenomena—was recognised and commented upon by early philosophers.[3] What is often overlooked is the related fact that any one set of objects can be classified in an infinite number of different ways, and that the choice of classificatory system depends entirely upon the intended purpose. A botanist might classify potato plants on the basis of their foliage, preferred climate, colour, size, shape and even DNA with a view to determining how they relate to one another in terms of common ancestry. A farmer is more likely to be interested in their potentials for yield, resistance to blight and the timing of harvest. A food retailer will be concerned with

[1] Oxford English Dictionary online (http://www.oed.com).
[2] See note 1, Chapter 1.
[3] See note 15, Chapter 1.

shelf life or resistance to bruising, consistency of size and appearance, whereas a chef is going to focus upon flavour and texture. Processed food manufacturers will have their own ways of classifying potatoes. In other words, each of these interests generates its own system for classifying potatoes. They overlap but they are different; certain botanically defined distinctions are associated with differences of colour or texture, but all varieties of potato can result in big ones, smooth ones, small ones and knobbly ones. Some blight-resistant varieties might be also be bruise resistant; others may not be. No single way of classifying potatoes provides a sufficient way of doing so that fulfils everyone's needs. In other words, there is no 'right' or 'wrong' way of organising knowledge about potatoes … it depends upon your reason for being involved with them in the first place. Classification of anything is the recognition and application of one set of similarities and distinctions, but at the expense of another, and which is chosen depends upon the reasons for classifying in the first place.

Diagnosis

'Diagnosis' refers to something quite different. Although the term is most commonly associated with medicine, as in *medical diagnosis*, 'diagnosis' is also used in many other contexts such as engineering, computer science and organisational studies. It refers to the process of discerning the causes of problems, and routes to their mitigation and solution. The word has etymological origins, which emphasise this more general sense of an analytical process.[4] Espousal by medicine has to be understood as a special case, of the analysis and discernment of underlying causes responsible for patients' symptoms and complaints. This is reflected in contemporary medical language, which refers to numerous different approaches to diagnosis, each of which is identified by the technology used to conduct it or context within which it is carried out. For instance, *clinical diagnosis* refers to the judgement a doctor or another healthcare professional makes on the basis of patient-reported symptoms, the patient's history and what the professional can detect in the course of a clinical examination. *Laboratory diagnosis* refers to a judgement made on the basis of chemical or microscopical analysis of blood, other body fluids or tissue samples. *Radiological diagnosis* is

[4] The Greek origin, as a verb, is *διαγιγνώσκειν* (to distinguish, discern), compounded from *δια* (through, thoroughly, asunder) plus *γιγνώσκειν* (to learn to know, perceive).

a judgement made on the basis of x-rays or other forms of medical imaging. A person may be given an *admitting diagnosis*, which is what the condition is thought to be when admitted to hospital for investigations, and a *discharge diagnosis* when those investigations have been conducted and their results taken into account. *Differential diagnosis* is a list of all conditions that might explain the presenting problem and clinical signs before more thorough analysis and investigations have been carried out. Someone might have their own opinion of their condition, which could be called *self-diagnosis* and, in certain circumstances, specific reference might be made to the perspective from which the problem is being considered. The professional literature refers to discussion and statements concerning nurses', physiotherapists' and occupational therapists' perspectives upon diagnosis. These are different from one another and from medical diagnosis. They reflect each profession's skills, tasks and interests.[5] In other words, even when used in a medical context *diagnosis* is not just a label, but the outcome of a process of elucidation, which can take many forms, depending upon the professional and technical contexts within which it is conducted.

Medical Diagnosis

When *medical diagnosis* occurs it is because a doctor has applied their particular skills and knowledge in an attempt to unravel what is causing their patient's symptoms. The doctor's professional expertise is rooted in an understanding of how the physical body functions: what various organs do, where they are located, what can go wrong with them, and which changes of function or obvious abnormalities point to dysfunction of which organs. Medical diagnosis is an attempt to identify how and why particular organs are not functioning properly in order to do something with drugs or with surgery that will correct or alleviate the problem. The process generally begins with taking a history or obtaining an account of the problems the patient has noticed and enriching it

[5] The North American Nursing Diagnosis Association (NANDA) has defined nursing diagnosis as 'a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes [which] provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable'. Physiotherapy diagnosis focuses upon the relationship between bodily impairments and functional limitations (see Guccione, 1991). Occupational therapy diagnosis summarises a patient's occupational deficits in terms of occupational role performance, occupational performance and the components of occupational performance (see Rogers and Holm, 1991).

by enquiry into more detail. A person may have noticed breathlessness on exertion. The doctor might want to know how long this has been going on for, whether it began insidiously or suddenly, whether certain postures are more strongly implicated and whether or not there are other possibly related symptoms such as cough, blood in the sputum, chest pain, light headedness or ankle swelling. Answers to all of these will help the doctor narrow down the otherwise very long list of known causes of breathlessness on exertion.[6]

Medical diagnosis might continue with the doctor carrying out a physical examination, in the course of which they are likely to check out hunches the history may have suggested. Is there a fever? Is the pulse regular, and not too fast or too slow? What is the blood pressure? Do the lungs sound clear? Are there any heart murmurs? Does the patient appear pale? Are there any signs of fluid retention or dehydration, or abnormal lumps to feel? This should narrow the list of possible reasons for breathlessness even further.

Finally, tests may be ordered. In a case such as this the doctor is likely to ask for a chest x-ray, which will give further information about the state of the heart and the lungs. A blood count will clarify whether or not the patient is anaemic and might also point to infection. An electrocardiogram and further blood tests can provide more information about the state of the heart. If all of this information points to coronary artery problems, then an angiogram might be appropriate,[7] and it might identify coronary artery blockages that could be alleviated by surgery. If there are signs of a growth in the lungs then a bronchoscopy and biopsy might clarify what sort of tumour it is and how far it has spread, with implications for how it might be treated.[8] If there is a fever and there are signs of lung infection then it may well be possible to find out from laboratory analysis of samples which bacterium or virus is responsible, and this will help to decide which antibiotic to use. Medical diagnosis is a process that unravels the patient's difficulties in a way that re-interprets

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[6] Undue breathlessness on exertion can be caused by unsatisfactory heart or lung function, serious anaemia, fluid retention due to kidney problems and a number of other problems. Mere 'breathlessness on exertion' does not distinguish between these and so it provides no pointer to what the underlying problem might be, and what might be done to alleviate it.

[7] An angiogram is a way of visualising blood vessels and it is commonly used to establish how blood flow in blocked or narrowed arteries might be improved.

[8] Bronchoscopy is a medical procedure that involves the use of a flexible telescope to look inside the lungs. Biopsy is the removal of a small tissue sample for laboratory analysis.

them as the consequences of potentially identifiable underlying abnormality or malfunction.

Medical Diagnosis and Classification

Although diagnosis can be used in reference to analytic processes outside of healthcare, and within healthcare by various professional groups other than doctors, common parlance generally associates it with something doctors do. They make diagnoses. This may well be experienced by the patient or their associates as the doctor making a pronouncement that gives the condition or set of complaints a formal name. 'What is the diagnosis?' generally means 'What does the doctor say is wrong?' This gives the condition a name—breast cancer, pneumonia, diabetes or another—and locates it in a particular box. That might be considered a form of classification but in reality it amounts to a lot more. When a doctor makes a medical diagnosis it means that they have applied their clinical skills and their ability to interpret the results of any blood tests or other investigations that may have been carried out. They have set out to unravel and provide an explanation of the patient's complaints in a way that employs their technology and grasp of medical knowledge, which are the essence of medicine's authority and contribution to society. When a doctor 'makes a diagnosis' they apply their skill and resources to unravel a patient's complaints in terms of causes and explanations drawn from the canon of medical knowledge.[9] A lump in the breast becomes a cancer as a result of a biopsy; cough, breathlessness and fever become pneumonia as a result of the doctor's examination, x-ray and microscopic examination of the sputum; weight loss, tiredness and thirst become diabetes as a result of blood sugar measurements reflecting disturbed sugar metabolism; and so on. No two breast lumps, coughs or experiences of tiredness are the same but by unravelling them in more detail the doctor can redefine them in terms that reflect agreed medical science's understanding of what is causing them and, importantly, what might be done about them. The breast lump becomes evidence of a malignant growth that might have spread further and demands further investigation, and which may be arrested by surgical removal and radio- or chemotherapy. Tiredness and weight loss become a disturbance of sugar metabolism that might

[9] A canon of knowledge is a body of knowledge that is 'owned' or makes up a particular constituency's agreed understanding of their subject matter. Applied to religious texts to identify what is and what is not considered part of Holy Scripture, but equally applicable to other forms of authorised opinion.

be corrected by the use of insulin, oral hypoglycaemic agents or diet.[10] Cough and breathlessness become a lung infection involving bacteria, which can be expected to respond to a particular course of antibiotics.

Medical diagnosis might well give the condition a name, or classify it, but the expectation is far more than that. The expression suggests that there is available medical expertise that can explain it, and quite possibly do something about it. When we speak of making a diagnosis much more is implied than just the fact that the condition has a medical name, fits a particular pattern or matches a set of diagnostic criteria. The use of the term *diagnosis* implies insight into underpinning mechanisms and offers an agreed explanation of why the condition has occurred. When a condition is *classified* by medical authority at the time that a doctor makes a diagnosis, this process of unravelling it and the expert knowledge it depends upon are assumed because that is what *diagnosis* is understood to mean. If that knowledge is not available and the condition is given a medical name simply because its features fit a particular pattern, or match certain diagnostic criteria, then the use of the term *diagnosis* cannot reflect the application of specialised knowledge and the insights that implies. It reflects nothing more than training in the skills necessary to recognise symptom patterns or diagnostic criteria. As a result, this use of *diagnosis* is misleading. It might be understood by psychiatrists as nothing other than *classification,* or an act of administrative necessity. For others, wider use of the word 'diagnosis' suggests that more has been achieved, that the professional has effective insight into how the condition has come about and what might be done to put it right. This is a core difficulty in psychiatry. ICD and DSM *diagnoses* are actually medically attributed *classifications*. Unfortunately, wider use of the term *diagnosis* implies more insight into mechanisms and treatment than *classification* ever purports to offer. Unrealistic expectations are raised and the result is widespread misunderstanding and frustration.

Other Potential Misunderstandings

Alongside *diagnosis* and *classification* there are three other widely used terms in medical circles, which have subtle distinctions of meaning that are frequently overlooked and, as a result, have important implications for misunderstandings in psychiatric circles. The words are 'illness', 'disease' and 'pathology'. As with *diagnosis* and *classification*, they are

[10] Oral hypoglycaemic agents are drugs that can be used instead of insulin injections in some forms of milder diabetes.

commonly used quite interchangeably, even though their meanings are nuanced and their finer distinctions are important. All refer to judgements concerning an individual's medical condition. The source and authority behind all sorts of judgements are strong influences upon how they are received, viewed by others or acted upon. A keen golfer is much more likely to work on their swing if criticised by the club coach than by another player whose style they don't respect. One's choice of builder is much more likely to be influenced by a friend who has employed them than by the builder's website or patter. One of the nuanced differences between *illness*, *disease* and *pathology* is that they refer to different sources of medical knowledge and opinion, and, as a result, they speak with different levels of certainty and authority. An important question for students of mental health difficulties and how they are viewed, is how these terms are used in psychiatry, and whether the implications of doing so are justified by what is inferred when they are.

Most commentators agree that *illness* refers to lay understandings and opinion.[11] A judgement about whether or not an individual is ill is commonly made by the person themselves or others around them. It might be confirmed by a medical person but a huge number of temporarily incapacitating and at times very uncomfortable episodes of illness such as 'flu or food poisoning follow their course without professional intervention, and there is rarely dispute over whether or not the person has suffered an illness. When a condition is considered an illness certain social consequences follow. In particular, the patient is accorded access to the sick role, a well-defined set of social arrangements that accommodate the circumstances of someone temporarily incapacitated by illness.[12]

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[11] Lay understandings or belief are terms commonly used in medical sociology to refer to everyday/nonprofessional discourse concerning medical matters in an attempt to distinguish it from professionalised medical discourse. This is not a clear distinction as everyday discourse concerning medical matters is not isolated from everyday experience of medical discourse (see Shaw, 2002).

[12] Talcott Parsons outlined the way in which the particular circumstances of a temporarily disabled person might be provided for in a way that maximised their chance of recovery, thereby providing a social framework to accommodate illness. Broadly, it describes the 'patient' accepting their incapacity and submitting to the authority of the 'doctor', the 'doctor' exercising professional skills and specialised knowledge others don't have access to, relieving the 'patient' of responsibilities, the 'patient' relinquishing autonomy over other aspects of their life, the 'doctor', close friends and family, and other elements of healthcare unquestioningly responding to the patient's needs with resources and emotional support, and the 'patient' agreeing that this is a temporary state of affairs and striving to recover to a state of returned autonomy and responsibilities (see Parsons (1951) and Williams (2005)).

Diseases are generally understood as specific entities: cancer, pneumonia, diabetes, coronary artery disease or rheumatoid arthritis. These are professionally defined as the doctor translates the patient's experiences of *illness* into their own medical language.[13] One without formal medical authority might accurately identify a state of affairs as the presence of this, that or another disease, but this would be based upon some familiarity with medical knowledge rather than independently of it (see Shaw, 2002). Reference has already been made to the way in which identifying a condition as a case of a particular disease is inescapably dependent upon the availability and application of specialised medical knowledge capable of providing an agreed explanation of how it has come about, and how it might be provided for. Such explanations are derived from the canon of medical knowledge and reflect professional consensus. They are generally couched in terms of what that medical consensus understands the processes causing an instance of ill health to be. *Diseases* are medical terms reflecting medicine's knowledge and insights into what might be causing this, that or a third *illness*: ICD-10 is indeed a classification of the many forms ill health can take, based upon medically agreed views of how they might be caused. That is, apart from the notable exception of Chapter V, 'Mental and Behavioural Disorders'. This terminological exception is considered in more detail later in the chapter.

Finally, although the term is also used interchangeably with *illness* and *disease*, the unique application of *pathology* is by way of reference to the study of disease processes.[14] Thus, the pathologist is someone who studies and identifies disease processes as they might be found in tissues or body chemistry, and pathology is what is actually found in the diseased person as a result of laboratory tests or medical imaging, during an operation or, should they die, a postmortem. As an academic discipline pathology plays a central part in medical education. Along with detailed study of normal bodily structure and function it provides the bedrock of the doctor's ability to interpret and integrate patients' complaints, symptoms, clinical signs and laboratory tests into a diagnosis by providing an understanding of how the body's usual mechanisms can

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[13] In the traditional doctor-centred approach to practice physicians try to bring the patient's illness into their own world and interpret the illness in terms of their own (i.e. the physician's) pathological frame of reference (see McWhinney, 1987).

[14] Ancient Greek origins: πάθος (*pathos*, 'feeling, suffering') and -λογία (*-logia*, 'the study of').

go wrong, and might have done so in any one particular case. Although a *disease* might be identified when a doctor elicits signs and symptoms other doctors would agree constitute strong evidence for the presence of a particular abnormality or pathology, that pathology is rarely judged to be present until or unless there is direct evidence of it from investigations or at postmortem. A singular feature of mental health difficulties is that with the exception of those attributable to organic brain disorder, none have been reliably associated with any evidence of abnormal laboratory test results, imaging or postmortem findings.

In other words, *illness*, *disease* and *pathology* refer to three overlapping but distinct sources of authority and knowledge that inform judgements about the status of an individual considered to be unwell. *Illness* reflects commonly held views that are informed by, but operate independently of, expert medical opinion. Whether or not a condition is identified as an illness is reflected in whether or not the condition qualifies the person for the particular arrangements of the sick role. *Disease* is a judgement based upon medical opinion, whether directly or by proxy, and it reflects the application of specialised medical knowledge to the task of explaining the condition. *Pathology* refers to what a consensus of expert medical and scientific opinion considers to be the damage or abnormality underpinning the condition. It reflects the results of laboratory and other investigations, and it is generally what experts would expect to find at postmortem were the person to die. In relation to mental health difficulties both *disease* and *pathology* are problematic terms. There is no generally agreed canon of medical knowledge, which might explain differing mental health difficulties and which would support notions of mental *disease*, concerning abnormal processes. Almost by definition, psychiatry concerns itself with conditions that are not associated with an identifiable *pathology.* Whether or not a condition is identified as an *illness* is, essentially, a socially mediated moral judgement rather than one based upon specialised medical knowledge and expertise. These distinctions raise critical questions about the validity of locating psychiatry within the wider world of other medical specialities.

Making a Medical Diagnosis

Given the distinct but overlapping implications of these three terms, truly medical discernment of a patient's difficulties, making a *medical diagnosis*, involves considering them simultaneously as evidence of *illness*, of *disease* and of *pathology*. In the course of moving on to the

special case of psychiatry, it is worth summarising how these interweaving considerations play out in more conventional medical contexts.

Firstly, the patient's complaints or difficulties have to qualify as a form of impairment generally accepted as *illness* before they can be considered a candidate for medical diagnosis. Repeated offending can be recognised as an incapacitating pattern of behaviour but it is not commonly recognised as an illness. Romantic love is easily recognised as something that happens to people, and it has hormonal and physiological concomitants, but only in the poetic sense of 'lovesickness' does it qualify as an illness. It is only *after* a condition has been acknowledged as an 'illness' by broader social consensus that it can then become subject to the process of medical diagnosis. This is not a rigid process. Medical opinion is rapidly incorporated into lay knowledge and opinions, and this is particularly true in the field of mental health difficulties. What might once have been considered unwelcome or troubling behaviour might acquire the status of 'illness' following the assimilation of emerging medical opinion into wider consensus,[15] and occasionally a condition once considered an 'illness' can become assimilated as generally acceptable, as has happened with homosexuality in many parts of the world over recent decades. Whether or not a condition is considered an 'illness' is essentially a social judgement strongly informed by medical opinion.

If and when a set of difficulties is recognised as an illness, medical diagnosis can proceed to the professional arena. Most often patients' complaints, clinical signs and test results fit a recognised pattern that medical and scientific opinion can readily agree upon as evidence of a particular form of bodily dysfunction. This gives value and authority to the medical diagnosis of a particular disease or injury. Clearly, certain courses of events and patterns of disturbed function are so stark that the full panoply of medical expertise is unnecessary. A very painful wrist that won't move after a fall is likely to be broken because most people have assimilated some medical knowledge and understand something about what bones are, what makes up a wrist and what can happen to it in the course of a heavy fall. A fair degree of understanding about how the body is made up, and what can go wrong with it, is widely assimilated general knowledge but, even so, medical knowledge out-ranks old

[15] See Conrad (1976) for an earlier account of this process in relation to the identification of attention deficit hyperactivity disorder; Horwitz and Wakefield (2007) in relation to depression; and Moncrieff (2014) for an account of ways in which emotionality has become identified as bipolar disorder.

wives' tales and other forms of lay understanding that disagree with it. It carries authority because it is derived from the study of pathology. Medical diagnosis incorporates the accumulated wisdom of those who have studied diseases in the living and the dead and have made connections between ways in which people suffer and what subsequently emerges at postmortem, or can be identified by x-ray or other investigations. It is familiarity with these connections that enables the doctor to say: 'These complaints, these clinical signs and these investigations mean that this is wrong, broken or not working properly, and might be fixed by taking this, that or another course of action'. It is only when these connections are known and articulated that medical diagnosis can add authority and value over old wives' tales and other lay opinions, and open up potentially useful access to medical resources and technology. If such connections are not available and cannot be inferred, then *diagnosis* is little more than an official name given to the condition for administrative or other purposes.

'Diagnosing' Mental Illness

As this chapter has already laboured in some detail, *classification* refers to the ordering of conditions according to a particular scheme developed for the purpose, and in itself this is not the same as *diagnosis*. 'What is your *diagnosis*?' may be experienced as a question about classification, but it is a particular form of classification. It is usually shorthand for 'What does the *doctor* say is wrong with you?' or 'What does your *medical* knowledge suggest is wrong with you?' A blurring of this distinction between *classification* and *diagnosis* as in the titles of ICD Chapter V and DSM is clearly there, contributes to misunderstandings and plays a major part in maintaining confusions about what psychiatry is, is not, and is or is not able to offer.

As Chapter 1 establishes, current versions of ICD Chapter V and the DSM have more in common than distinguishes between them. Using the terms '*Classification* of Diseases' and '*Diagnostic* (and Statistical) Manual' interchangeably, as they do, obscures some of the shortcomings both have when applied to mental and behavioural disorders. 'Classification of Diseases' implies the ordering of conditions on the basis of disease categories and, as outlined in earlier sections of this chapter, identifying a condition as a particular *disease* implies the availability and application of agreed medical knowledge that provides an explanation of the condition in terms of underlying processes or mechanisms, or *pathology*. *Pathology* is what would be apparent at

postmortem, were that to occur, or could be demonstrated in the laboratory, were it ethical to conduct sufficiently invasive investigations. This logic is readily illustrated by reference to the section of ICD Chapter IX that refers to myocardial infarction.[16] ICD Chapter IX differentiates a number of subtypes of myocardial infarction on the basis of their timing, recurrence and the location within the heart. Complications such as dysfunction of one of the heart valves, irregularities of the heart's rhythm or failure to maintain an adequate blood pressure are all defined in anatomical or physiological terms, which might have to be inferred by imaging, electrocardiography or other investigations in the living patient, but the basis of these inferences is expert knowledge of cardiology developed out of laboratory and postmortem studies accumulated over many years. Similarly, the classification of diseases of the liver, which is covered in ICD Chapter XI, refers to a variety of conditions such as hepatitis, cirrhosis, hepatic fibrosis and hepatic sclerosis. These are all defined in terms of the microscopic appearance of liver tissue, which can be obtained relatively safely by percutaneous liver biopsy.[17] As a whole, ICD-10 comprises 22 chapters. Three provide codes for circumstances such as factors influencing access to healthcare, or signs and symptoms not classified elsewhere; two refer to injury, poisoning and other external causes of morbidity and mortality; and two consider conditions associated with pregnancy and the postnatal period. Chapter I refers to certain infectious and parasitic diseases. Chapter II classifies neoplasms,[18] and Chapter XVII refers to congenital malformations, deformations and chromosomal abnormalities. The remaining 12 chapters, apart from Chapter V, classify diseases on the basis of the anatomically and physiologically defined organs and organ systems involved, and the potentially observable pathology understood to be responsible for the condition. Infectious and parasitic diseases are defined by the presence of a virus, a bacterium or a parasitic organism that can be identified in the laboratory. A neoplasm is identified on the basis of particular abnormalities in the microscopic appearance

[16] Myocardial infarction is defined as the death of heart muscle cells due to an interruption of their blood supply and it is a common cause of what is more colloquially known as a heart attack.

[17] Percutaneous liver biopsy is the extraction of a small piece of liver tissue from a living patient for laboratory analysis. It involves inserting a special needle through the skin and into the patient's liver, usually under local anaesthetic.

[18] Neoplasm (new growths) is a general term for all forms of cancer or malignant tumours.

of the growth or tissue in question,[19] and congenital malformations, deformations and chromosomal abnormalities are defined as conditions that have arisen as a result of abnormal fetal development at some stage from conception onwards.[20] In other words, the ICD classifies medical conditions according to organ or organ system considered to be involved and medical consensus concerning the underlying disturbance of function, or *pathology*. In doing so it conforms to the widely held understanding of the term *disease*; namely, a term applied to the understanding of a condition once it has been subject to medical gaze and interpreted in the light of specialised medical knowledge concerning underlying mechanisms. ICD is very clearly a classification based upon specialised medical interpretations of what might be causing patients' difficulties. That is to say, apart from Chapter V.

With the exception of the first two subchapters, which refer to mental and behavioural disorders due to organic causes and those due to psychoactive substance use, respectively, Chapter V classifies mental and behavioural disorders without reference to any consensus concerning causes and underlying mechanisms, or even an attempt to derive one. Conditions are grouped and differentiated entirely upon their external appearance; the presence or otherwise of behavioural phenomena such as avoidance, suspicious reactions to others, angry outbursts, abnormal eating patterns, dependency or unusual sexual behaviour, the reported presence or otherwise of certain subjective experiences such as others' voices, apparently unattributable fear, undue elation or misery, or idiosyncratic beliefs, a threatening demeanour, anxiety or confusion to

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[19] All neoplastic, malignant or cancerous tissues show signs of chaotic and irregular growth and proliferation when viewed under the microscope.

[20] Congenital conditions can include the consequences of inheriting a gene responsible for abnormal function or metabolism (e.g. cystic fibrosis (CF), sickle cell anaemia (SCA) or phenylketonuria); abnormal germ cell development (e.g. Down's syndrome or fragile X syndrome); or an abnormality of fetal growth itself (e.g. spina bifida or various forms of congenital heart disease). The ICD classifies congenital conditions due to the first of these as diseases of the organ system or tissue concerned. As they are known to be due to abnormalities of cellular metabolism, CF and phenylketonuria are classified as metabolic diseases, whereas SCA is classified as a disease of the blood and blood-forming organs. Congenital conditions due to abnormalities of germ cell development or of fetal growth are classified on the basis of the parts affected or, if generalised, as chromosomal abnormalities not otherwise classified. Spina bifida or a congenital heart defect would be classified as congenital malformations of the spine or of the heart respectively; Down's syndrome as a chromosomal abnormality not otherwise classified.

list some. A great deal of research effort and other resources have been invested in ensuring that the ICD classification based upon these and related phenomena is reliable,[21] but it remains true that apart from behavioural disorders due to organic causes and those attributable to psychoactive substance use, consensual understandings of underlying mechanisms play no part in the criteria upon which it bases its *diagnoses*. The psychiatric and psychological literatures burgeon with proposals, theories and explanations offering their understandings and interpretations of mechanisms underlying all forms of psychological difficulty and distress, but there is little agreed fact upon which to base consensus, and therefore little scope for a reliable scheme of classification derived from it. As a result, ICD Chapter V is not a classification of *diseases* in the sense that the term 'disease' is used throughout the rest of ICD. Its sponsor, the WHO, has respected this and notably avoids use of the term in the title of Chapter V, which is 'Mental and Behavioural *Disorders*'. As this is nevertheless presented and published as an integral part of the International Classification of *Diseases*, it is not surprising that there are misunderstandings over the epistemological status of conditions generally known as 'mental illnesses',[22] and the bases upon which they are identified and delineated.

DSM is explicitly titled the '*Diagnostic* and Statistical Manual'. Understandably, the APA does not provide a glossary of physical conditions against which to compare their use of the term 'diagnosis' in relation to the definition of mental health difficulties, and their understanding of it in a wider medical context. Nevertheless, the authors are clear that DSM does not even attempt to classify mental and behavioural disorders on the basis of insights into their causes or underlying mechanisms, and explicitly state that theirs is an exclusively descriptive approach. The reason for this is understandable and acknowledged. It is that knowledge that might provide insight into the causes and

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[21] The quality of any scheme of classification can be considered in terms of its reliability and its validity. Reliability refers to the success with which it returns the same result under differing circumstances and when used by different investigators. Validity refers to the success with which a scheme of classification fulfils its intended purpose.

[22] Epistemology refers to the study of knowledge. The word is derived from the Greek *πιστήμη* (*epistēmē*), meaning 'knowledge, understanding', and *λόγος* (logos), meaning 'study of'. In this context epistemology refers to the origins or background of the knowledge upon which and with which 'mental illnesses' are studied and understood.

mechanisms of most mental disorders just doesn't exist. To quote from DSM-III-R,

> For most of the DSM-III-R disorders, however, the etiology is unknown. Many theories have been advanced and buttressed by evidence—not always convincing—attempting to explain how these disorders come about. The approach taken in DSM-III-R is atheoretical with regard to etiology or pathophysiological processes, except with regard to disorders for which this is well established and therefore included in the definition of the disorder (American Psychiatric Association, 1987, p. xxii).

This refers to 'Organic Mental Disorders', which can be considered to have known aetiologies, and 'Adjustment Disorders', which, by definition, are considered to be psychological reactions to identified events in the person's life. It then continues:

> The major justification for the generally atheoretical approach taken in DSM-III-R with regard to etiology is that the inclusion of etiologic theories would be an obstacle to use of the manual by clinicians of varying theoretical orientations, since it would not be possible to present all reasonable etiologic theories for each disorder. For example, Phobic Disorders are believed by many to represent a displacement of anxiety resulting from the breakdown of defence mechanisms that keep internal conflicts out of consciousness. Others explain phobias on the basis of learned avoidance responses to conditioned anxiety. Still others believe that certain phobias result from a dysregulation of basic biological systems mediating separation anxiety. In any case, clinicians and researchers can agree on the identification of mental disorders on the basis of their clinical manifestations without agreeing on how the disturbances come about.

The standard edition of DSM-5 makes no specific reference to aetiology whatsoever.

As with the ICD-10, considerable research effort has been invested in making the DSM-5 a reliable system of *classification* but the use of the term *diagnosis* is misleading if it is understood to reflect the application of specialised medical insight into causes and underlying mechanisms. Instead, a condition or a person acquires a particular psychiatric *diagnosis* for the rather circular reason that their symptoms and experiences fulfil certain diagnostic criteria. As outlined in Chapter 1, DSM-5

would define major depressive disorder as the presence of five or more symptoms that have been present during the same two-week period, mark a change from previous functioning, include at least one of depressed mood or loss of interest or pleasure, and the remaining three or four from significant weight loss or weight gain, sleep disturbance, agitation or slowed movements and thinking, fatigue, feelings of worthlessness or excessive guilt, diminished ability to think or concentrate, or recurrent thoughts of death or recurrent suicidal ideation. The possibility that a significant loss such as bereavement, financial ruin or serious medical illness might be associated with symptoms that may resemble a depressive episode is acknowledged, but even under these circumstances a distinction is attempted between major depressive disorder and the consequences of loss (American Psychiatric Association, 2013, p. 161). In other words, a person will acquire a 'diagnosis' of major depressive disorder entirely on the basis of whether or not their difficulties fulfil diagnostic criteria, quite independently of any interest in likely causes such as clearly understandable reasons for feeling dejected. Similarly, a person would acquire a DSM-5 diagnosis of schizophrenia if they experienced (i) two of delusions,[23] hallucinations,[24] disorganised speech,[25] grossly disorganised or catatonic behaviour,[26] or negative symptoms,[27] flat or grossly inappropriate affect; (ii) functioning in such areas as work, social relations and self-care markedly below the highest level achieved before onset of the disturbance (or, when the onset is in childhood or adolescence, failure to achieve expected level of social development); and (iii) continuous signs of the disturbance for at least six months.

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[23] False personal beliefs based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (i.e. it is not an article of religious faith) (American Psychiatric Association, 2013, p. 87).

[24] A sensory perception without external stimulation of the relevant sensory organ (American Psychiatric Association, 2013, pp. 87–8).

[25] Incomprehensible shifts of topic (derailment of loose associations), oblique conversational connections (tangentiality) or complete incoherence (American Psychiatric Association, 2013, p. 88).

[26] Marked motor (movement) abnormalities, generally limited to disturbances within the context of a diagnosis of a nonorganic psychotic disorder (American Psychiatric Association, 2013, p. 88).

[27] Diminished emotional expression, impaired volition, social withdrawal (American Psychiatric Association, 2013, p. 88).

These are detailed criteria, and the singular achievement of DSM has been to provide a clear and reliable scheme for the classification of mental disturbances based upon explicit and notionally reproducible criteria. DSM-5 is derived, effectively, from DSM-III, which was published in 1980 and developed in response to a variety of calls for reliability amongst psychiatric diagnoses. As these two examples illustrate, *diagnosis* is based upon detailed and often quite complex diagnostic criteria, and judgements concerning them often require specialised skills and training if the scheme's potential for reliability is to be fulfilled. Making a DSM diagnosis, or indeed classifying a mental disorder using ICD Chapter V criteria, has become a specialised task reserved for those with the necessary training. It depends upon the ability to elicit and precisely identify otherwise unfamiliar phenomena such as slowed thinking and movements, excessive guilt, catatonic behaviour or thought broadcasting. Fluent grasp of the diagnostic criteria enshrined in either or both of DSM and ICD is one of the requirements for membership of the Royal College of Psychiatrists or completion of the APA's Board Certification. Knowledge of those criteria and the skills necessary to apply them are core features of psychiatric training and essential expectations of the trained psychiatrist. Applying them is central to what medical psychiatrists do in practice and so when they are called upon to give an official name to a particular condition it is barely surprising that the process is generally understood to be comparable to that of making a diagnosis by a physician or a surgeon. Unfortunately, it does not include the ability to engage and employ useful and reliable knowledge concerning causes and underlying mechanisms that physicians and surgeons have to hand.

This is fully acknowledged by the APA (American Psychiatric Association, 2013, pp. 19–21), but what are overlooked are the grave misunderstandings that have arisen as a result of presenting a scheme of classification as a diagnostic manual. The authors of ICD Chapter V and the DSM have created impressive, comprehensive and generally reliable schemes for *classifying* mental health difficulties but these are not substantive *diagnostic* classifications or classifications of *diseases* if the important nuances of meaning between these terms are to be fully acknowledged. They might appear to be diagnostic manuals insofar as the knowledge and skills necessary to apply them tend to be held by doctors, but they quite explicitly do not provide the insight into causes and mechanisms that is implied by the use of the terms *diagnosis* and *disease* in other fields of medical endeavour.

That is why this obfuscation makes a strong contribution to misunderstandings about the relationship between mental health difficulties

and medicine. It is not the only contributor to such misunderstandings, and subsequent chapters will draw attention to others, such as the historical background to current provision for those whom psychiatry is charged to serve, and the need for an acceptable source of authority if public safety is to be maintained in the face of the truly dangerous or the self-destructive. However, the inappropriate use of the term 'diagnosis', with all the medical implications that come with it in a context where available knowledge cannot support that use, is a major contribution. Of course, many psychiatrists and other mental healthcare practitioners are aware of this and only pay lip service to the ICD and DSM.[28] Many would argue that they do conduct *diagnosis* in addition, perhaps, to making an ICD or DSM *classification*, and might well refer to this as formulation.[29] Nevertheless, DSM and ICD dominate the languages of statutory bodies, clinical trials, funding agencies, psychiatric education, and media comment and representations of mental health difficulties. As a result, the misunderstandings they embody, in particular, implicit communication of the view that acquiring a psychiatric *diagnosis* is no different from acquiring a medical diagnosis, are widespread and influential. Psychiatric 'diagnosis' is not based on the same quality of knowledge that underpins medical diagnosis. As a result, it does not, in itself, amount to an authoritative view of how the mental health difficulties in question might have come about or how they might be addressed. Quite clearly, if expectations raised by the impression that psychiatric and medical diagnosis are comparable cannot be met, then there is enormous potential for frustration and disappointment amongst those seeking the same degree of technical insight and clarity from psychiatry that they may be familiar with elsewhere in medicine. When a psychiatrist does offer helpful insight it is generally not because they have identified the 'diagnosis'—the ICD or DSM classification—but because they have been able to understand the individual and interactions between them and important others, and the difficulties they are experiencing. These are not integral features of making an ICD or DSM diagnosis. They depend upon the practitioner developing an understanding and

[28] This is illustrated by a survey of the use of DSM in everyday mental health settings (Brown, 1987), and a review of the small part ICD and DSM diagnoses play in determining treatment decisions (Middleton, 2008).

[29] Formulation is a structured way of summarising a case in terms of predisposing, precipitating and maintaining influences upon the difficulties a person might be suffering. It is favoured by nonmedical mental health practitioners but also recommended in some psychiatric textbooks (Gelder et al., 1989, pp. 69–71).

empathic relationship with their client, a process quite different from applying the skills involved in detecting the presence or absence of so-called diagnostic criteria. Psychiatrists' training in the application of ICD or DSM might support their use of these as schemes of classification but it does not, in itself, support their diagnostic skills insofar as they refer to the ability to understand and unravel their clients' difficulties. Those depend upon something different, which is a much less explicit feature of their training and institutional expectations of them.

3
Psychopharmacology: The Medicines of Psychiatry

Alongside misunderstandings attributable to inappropriate use of medical terms such as 'diagnosis', 'disease' and 'pathology' in relation to mental health difficulties, a parallel set of misunderstandings has developed around the parts drug treatments can play in alleviating them. This use of medicines is known as psychopharmacology: the study and use of drugs as treatments for mental health difficulties. Drugs of one sort or another have played a part in alleviating human distress from time immemorial. Alongside their use as intoxicants, alcohol, opium and other preparations have been used for their calming and anaesthetising properties since ancient times. Indeed, alcohol in over-ripe fruit may play an evolutionarily role in attracting small primates, who, in their turn, play a part in dispersing seeds (Dudley, 2004). Contemporary psychiatry relies heavily on medicines. Much of the recent history of the profession is that of the development, use and evaluation of drug treatments. Understanding contemporary psychiatry is impossible without an understanding of the drugs psychiatrists use, their properties and their shortcomings.

What follows is an account of how psychopharmacology is presented in standard textbooks. It begins with an outline of how psychopharmaceuticals are classified, and continues with more details of medicines falling into each of those classes, along with a description of how their various rationales for use have developed and information about their side effects and shortcomings. This will be of use to readers seeking this level of detail for professional purposes, but it should also be accessible to the more general reader. Explanations of more technical terms can be found in the notes.

Most medicines are marketed under a brand name that differs from their scientific, chemical or generic name because what is marketed is a

pill or an injection containing the drug in question in ways that might differ from product to product. Brand names differ from jurisdiction to jurisdiction and so generic names have been used in the text. A table is provided to help the reader relate these to what might be more familiar brand names currently in use in the UK and the USA (see Table 3.1).

Table 3.1 Psychiatric drug names

Generic name	**UK brand names***	**US brand names***
Acamprosate	Campral	Campral
Alprazolam	Xanax	Xanax, Niravam
Amisulpride	Solian	*Not approved for use*
Amitriptyline		Elavil/Levate
Amphetamine	Adderall	Adderall
Aripiprazole	Abilify	Abilify
Atomoxetine	Strattera	Strattera
Buspirone	Buspar	Buspar
Carbamzepine	Tegreto/Carbagen	Tegreto/Equetro
Chloral hydrate	Welldorm Elixir	Noctec
Chlordiazepoxide	Librium/Tropium	Librium
Chlormethiazole	Heminevrin	
Citalopram	Cipramil	Celexa
Clobazam	Frisium	Onfi
Clomipramine	Anafranil	Anafranil
Clozapine	Clozaril/Denzapine	Clozaril/Fazaclo
Diazepam	Valium	Valium
Disulfiram	Antabuse	Antabuse
Dosulepin	Prothiaden	*Not approved for use*
Duloxetine	Cymbalta/Yentreve	Ariclaim/Xeristar
Escitalopram	Cipralex	Lexapro
Fluoxetine	Prozac	Prozac/Sarafem
Flupentixol	Depixol/Fluanxol	*Not approved for use*
Flurazepam	Dalmane	Dalmane
Fluvoxamine	Faverin	Luvox
Haloperidol	Serenace	Haldol
Imipramine	Imipramine	Tofranil
Isocarboxazid	Isocarboxazid	Marplan
Lamotragine	Lamicital	Lamicital
Lithium carbonate	Priadel/Camcolit/Liskonum	Eskalith
Lofepramine	Lomont/Feprapax	Feprapax

(*continued*)

Table 3.1 Continued

Generic name	UK brand names*	US brand names*
Lorazepam	Ativan	Ativan
Meprobamate		Miltown/Trancot
Methylphenidate	Ritalin/Concerta	Ritalin/Concerta
Mirtazapine	Zispan	Remeron
Naltrexone		Vivitral
Nitrazepam	Mogadon/Somnite	
Nortriptyline	Allegron	Aventyl/Pamelor
Olanzapine	Zyprexa/Zypadhera	Zyprexa
Oxazepam		Serax
Paliperidone	Invega	Invega
Paroxetine	Seroxat	Paxil/Pexeva
Phenelzine	Nardil	Nardil
Pregabalin	Lyrica	Lyrica
Propranolol	Bedranol/Syprol	Inderal/Innopral XL
Quetiapine	Seroquel	Seroquel
Reboxetine	Edronax	*Not approved for use*
Risperidone	Risperdal	Risperdal
Sertraline	Lustral	Zoloft
Sodium valproate	Depakote/Epilim/Episenta	Depacon/Depakote
Sulpiride	Dolmatil/Sulpor	*Not approved for use*
Temazepam		Restoril
Tranylcypromine	Parnate	Parnate
Trazodone	Molipaxin	Desyrel/Oleptro
Venlafaxline	Efexor	Effexor
Zaleplon	Sonata	Sonata
Zolpidem	Stilnoct	Ambien
Zopiclone	Zimovane	Imovane
Zuclopenthixol	Clopixol Acuphase	*Not approved for use*

*Assumed to be registered trademarks or copyright.

Standard textbook accounts tend to communicate the view that the use of medicines for the treatment of mental health difficulties can follow a simple logic. Anxiety can be treated with the use of anxiolytic (anti-anxiety) agents, depression with antidepressants, psychosis with antipsychotics, mood disturbances with mood stabilisers, and attention problems in children and young adults with stimulants and other agents. It is seductively and deceptively simple, disarmingly so. As the following account makes clear, the quality of scientific knowledge behind this is very poor.

Textbook accounts tend to gloss over several important criticisms of any drug-based approach to mental illness. Chapter 4 takes up these issues, explores them in more detail and offers a more candid understanding of how the effects of psychopharmaceuticals might be understood.

Classifying Psychopharmaceuticals

There is a bewildering array of psychiatric medications. Most authorities boil the list down to a small number of categories based upon the uses they tend to be put to. The British National Formulary (BNF) provides information about 'psychiatric' medicines under four main headings.[1] These are 'hypnotics and analgesics', 'drugs used in psychoses and related disorders', 'antidepressant drugs' and 'central nervous system stimulants and 'drugs used for attention deficit hyperactivity disorder'. Along with information and advice concerning drugs used to control pain (analgesics), antiepileptic medications, drugs used for Parkinson's disease and related conditions, drugs used to control vertigo and nausea, drugs used in the treatment of obesity, and drugs used in the management of substance dependencies and in the treatment of dementia, make up the central nervous system section of the BNF. This reflects the fact that they are medicines considered to act primarily upon the brain and other parts of the nervous system in order to address conditions attributable to those parts of the body. Other sections of the BNF provide information and advice concerning drugs used because of their actions upon the gastrointestinal system, the cardiovascular system, skin, muscles and joints, and so on.

A popular undergraduate clinical pharmacology textbook refers to drugs used for the treatment of psychiatric disorders in terms of 'Antipsychotic Drugs', 'Antidepressants', 'Mood Stabilising Agents', 'Anxiolytics', 'Hypnotic Drugs and the Treatment of Insomnia', 'Drugs used in the Management of Substance Abuse' and 'Drugs used in the Treatment of Dementia' (McKay and Walters, 2013),[2] and one of the standard psychiatric reference text books considers them in terms of 'Anxiolytics and Hypnotics', 'Antidepressants', 'Lithium and

[1] The BNF is jointly published by the British Medical Association and the Royal Pharmaceutical Society. It provides information and prescribing guidelines that cover all licensed medicines available to British prescribers in the form of a regularly updated summary. The BNF is a central point of reference for much of British medical practice and medical practices in other similar jurisdictions.

[2] The treatment of psychiatric disorders is covered by McPhee (2013, pp. 97–110).

Related Mood Stabilizers', 'Antipsychotic and Anticholinergic Drugs', 'Antiepileptic Drugs', 'Drugs for Cognitive Disorders' and 'Drugs Used in the Treatment of the Addictions' (Gelder et al., 2009).[3] These are all oversimplifications and many people taking medicines for mental health difficulties will be taking drugs from more than one of these categories. Furthermore, the notion these classifications suggest, that mental health difficulties can be neatly parcelled into one or another of several clearly defined diagnoses, is itself questionable (Middleton, 2008). Nevertheless, a full understanding of psychiatric practice has to include an understanding of how it is practised by those who are charged to do so. This is how drug treatments for mental health difficulties are generally presented in professional circles, with one exception. Medicines used in the treatment of Alzheimer's disease and other forms of organic dementia are not discussed. This is because these conditions are better thought of as truly medical, as there is no doubt that they are due to the degeneration of brain tissues. The implications of this are discussed in more detail in Chapter 7.

Anxiolytics and Hypnotics

Anxiolytics and hypnotics are all drugs that reliably cause sedation. Anxiolytics are used to relieve troubling anxiety and hypnotics are used to aid sleep but, in fact, they are closely related. Most anxiolytics are compounds that come from the chemical family, benzodiazepines. Commonly used benzodiazepines include alprazolam, chlordiazepoxide, clobazam, diazepam, lorazepam and oxazepam. There is very little difference between these other than their duration of action. All act in a similar way, which is thought to be by enhancing the activity of neuroinhibitory pathways that normally dampen activity in a wide range of neuronal circuits. The implicated neurotransmitter is gamma-aminobutyric acid (GABA),[4] and benzodiazepines are thought to act upon nerve cells that communicate with others by releasing GABA. Such nerve cells are widespread throughout the brain and they are thought to

[3] Contributions concerning psychopharmacology by several authors make up the larger part of Section 6.2, pp. 1169–271.

[4] A neurotransmitter is a chemical released by one nerve cell that activates another, thus passing on a 'message', or impulse, from nerve cell to nerve cell. Neurotransmitters are the 'brain chemicals' of popular imagination that are susceptible to manipulation by drugs and are therefore one of the main mechanisms through which medicines can alter neuronal activity.

have an inhibitory effect upon the activity of those they communicate with. Thus, the effect of benzodiazepines is considered to be a generalised quietening of nerve cell activity. This is usually experienced as pleasant sedation, not unlike intoxication with alcohol. As with alcohol intoxication, the inhibition of inhibitions can also result in embarrassing, impulsive or unwise behaviour. Furthermore, as with alcohol intoxication, excessive benzodiazepine can result in motor incoordination, causing clumsiness and difficulties with gait, sleepiness and, if extreme, loss of consciousness. In the short term benzodiazepines do relieve anxiety but this is at the cost of psychological skill and coordination, and they are now clearly understood to be addictive. The clinical use of benzodiazepines began with chlordiazepoxide in 1960.

Compared with barbiturates, which were the sedatives and tranquillisers most widely used during the first half of the twentieth century, benzodiazepines are relatively safe. An overdose or excessive use of barbiturates can cause respiratory arrest (breathing difficulties) and death. That is an extremely unusual outcome of the injudicious use of benzodiazepines, and so when they were introduced they were heralded as a much safer improvement in the alleviation of mental distress with tranquillisers. During the 1960s and 1970s benzodiazepines, in particular chordiazepoxide, under the trade name of Librium®, and diazepam, under the trade name of Valium®, were used very widely.[5] By the end of the 1970s it was becoming clear that they were not innocuous. Tolerance develops and any helpful effects can wear off.[6] Memory can become impaired. Anxiety and mental anguish can return unless the dose is increased, and any attempt to stop taking the drug is met with serious and distressing withdrawal effects. By the end of the 1980s benzodiazepines had acquired a bad name. Contemporary advice and medical teaching now discourage their use apart from under exceptional circumstances, and even then for only short periods of time. There are those who have had readier access to benzodiazepines, either during the time when they were more widely used, as a result of injudicious prescribing, or from black market sources. Under these circumstances

[5] The practice is immortalised in the Rolling Stones' song 'Mother's Little Helper', which was released in 1966.

[6] Drug tolerance refers to changes in sensitivity to a medicine during prolonged use in which the target or the receptors it acts upon alter their sensitivity or availability and reduce its effects. The result is that the drug ceases to be effective unless it is given at an increasingly high dose, and that if it is stopped for any reason, serious withdrawal effects follow.

dependency may have developed and those afflicted might find it difficult to manage without a regular supply. This is an occasional source of conflict between prescriber and patient, which sometimes results in difficulties due to abrupt withdrawal. If a person has become dependent upon benzodiazepine medication then the reality of that should be acknowledged and provided for in the form of a mutually agreed programme of slowly progressive withdrawal.

Other medicines listed as anxiolytics include pregabalin, buspirone, beta blockers such as propranolol, and some more historical entries such as chloral hydrate and meprobamate, which are no longer in routine use. Pregabalin is thought to act upon the same neuronal systems as the benzodiazepines, namely those for which GABA is the neurotransmitter. Initially introduced as an anticonvulsant to be used in the treatment of epilepsy, pregabalin is now advocated by some for the treatment of some forms of anxiety. This use is in its early stages. Given their similarities of action a balanced view should be that it is too early to assume that pregabalin will not turn out to be as addictive as the benzodiazepines. Withdrawal effects have been reported in internet forums. Buspirone has different chemical properties. It is thought to act upon serotonin neurotransmission, in some ways not unlike drugs otherwise referred to as antidepressants. Beta blockers are drugs that are primarily used in cardiovascular medicine to slow the heart and lower blood pressure. Propranolol is the beta blocker most commonly used as an anxiolytic. It does exert some calming effects but propranolol is used primarily, not because it acts in the brain, but because it inhibits palpitations and other physical features of anxiety.

Listed hypnotics, or drugs used to aid sleep, include benzodiazepines with a fairly rapid onset of effect such as nitrazepam, temazepam and flurazepam, and the so-called Z-drugs.[7] The Z-drugs include zopiclone, zolpidem and zaleplon. Although these are not members of the benzodiazepine family of compounds they are thought to act in a very similar way in that they influence GABA neurotransmission. Other listed hypnotics include

[7] The speed with which a drug takes effect and the duration of its actions can be manipulated by engineering the affinity of the molecule for water and/or for lipids (fatty molecules such as those making up cell membranes and fatty tissues), its metabolism or breakdown, the rate at which it is excreted by the body and whether or not any breakdown products are active in their own right. These properties are what is known as the drug's pharmacokinetics, and by adjusting the pharmacokinetics by adjusting details of the molecular structure a family of drugs with a common mechanism of action, such as the benzodiazepines, can include agents with rapid or slow onsets of effect and long or short durations of action.

historical entries such as chloral hydrate and chlormethiazole, which are now rarely used, melatonin, and antihistamines. Melatonin is a naturally occurring hormone secreted by the pineal gland, which is thought to play a part in regulating circadian rhythms.[8] Its use as a children's hypnotic has become fashionable but there may be wisdom in resisting the broad use of a natural hormone that has widespread and only partially understood effects amongst young people. Antihistamines, primarily used in the treatment of allergic conditions such as hay fever and certain forms of dermatitis, are sedating and sometimes find a place in the management of insomnia, but they are prone to causing daytime drowsiness.

The benzodiazepines' fall from grace has had a significant effect upon the popularity of prescribing for insomnia. During the middle of the twentieth century 'popping a sleeper' was widespread practice. More recent and justifiable concerns about dependency, hangover and other side effects have made it less popular and doctors more resistant to endorse it. Contemporary developments in the form of the Z-drugs and melatonin have done little to alleviate such concerns. Overall, however, the use of hypnotics and anxiolytics has not decreased, despite greater awareness of their shortcomings.

Antidepressants

Antidepressants have become some of the most widely prescribed medicines in the world, and the controversies that reflects and has generated are discussed in Chapter 8. Antidepressants are a collection of different sorts of chemicals, with a diverse range of actions. For present purposes they can be considered a group of compounds that are thought to alter the activity of nerve cells that rely upon serotonin (5-hydroxytriptamine) or noradrenaline as their main neurotransmitter. Neurons that use serotonin or noradrenaline as their main neurotransmitter mediate aspects of what has been considered the brain's arousal mechanism.[9]

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[8] Circadian rhythms are the patterns of fluctuation in bodily processes, particularly hormones.

[9] Much of the serotonin and of the noradrenaline in the brain is known to come from nerve cells that originate in the lower, evolutionarily more primitive part known as the brain stem, and extend into the upper, evolutionarily more recent parts known as the cerebral cortex. These connections are part of what was once known as the ascending reticular activating system. Although neuroscience now offers a more sophisticated interpretation of their role, this association with arousal mechanisms has provided a rationale for their part in psychological disturbances interpretable as 'depression'.

Historically, antidepressants are drugs whose pharmacological properties have been presented as the ability to amplify neurotransmission mediated by these neurotransmitters. An important control, part of the engineering of the synapse that regulates how readily one nerve cell activates another, is clearance of the neurotransmitter from the synaptic cleft.[10] If the neurotransmitter is cleared quickly the synapse is relatively unresponsive and 'messages' have to be of relatively high frequency to be transmitted. If neurotransmitter clearance is slow or hindered then the synapse will be relatively sensitive and 'messages' more easily transmitted. In very broad terms antidepressants are drugs that are thought to hinder the clearance of serotonin and/or noradrenaline from synapses that employ them, and, as a result, increase the sensitivity of connections between serotonin and/or noradrenaline releasing nerve cells and others. It is now known that this is a considerable oversimplification of what actually determines whether or not a 'message' is passed from one nerve cell to another, but the intricacies of receptor up- and downregulation, changes in receptor sensitivity, autoregulation and synaptic second messengers are beyond the scope of this discussion. The interested reader might turn to a more comprehensive neuroscience textbook (e.g. Squire et al., 2013).

Drugs are chosen for development as an antidepressant because, in the laboratory, they have been shown to block the reuptake of serotonin and/or noradrenaline from the synapse or inhibit their breakdown. How the therapeutic property of 'antidepressant' came to be associated with these pharmacological properties is another matter and one discussed below. The consequences are that the majority of 'antidepressants' are selective serotonin reuptake inhibitors (SSRIs), noradrenaline and serotonin reuptake inhibitors, tricyclic antidepressants (TCAs; which are an earlier form of noradrenaline and serotonin reuptake inhibitor) and monoamine oxidase inhibitors (MAOIs). Monoamine oxidase is an enzyme that breaks down noradrenaline and serotonin, and therefore plays a significant part in clearing them from synapses where they might have been acting as neurotransmitter. Inhibiting it can be seen as a way of increasing synaptic noradrenaline and/or serotonin.

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[10] Synapse is the term given for a connection between nerve cells. One nerve cell activates another by the diffusion of a neurotransmitter released by the 'upstream' nerve cell across a small gap (synaptic cleft) between it and the 'downstream' nerve cell, where it binds with receptors on the outside of the 'downstream' nerve cell and activates it if conditions are right in a number of other respects.

Selective Serotonin Reuptake Inhibitors

The most widely prescribed antidepressants are the so-called SSRIs. These include fluoxetine, originally under the trade name Prozac®, fluvoxamine, sertraline, paroxetine, escitalopram and citalopram. Adverse effects include gastrointestinal symptoms such as nausea, vomiting, dyspepsia, abdominal pain and constipation, and weight changes, both gain and loss. Sexual dysfunction, notably erectile impotence in men, is common. Most notoriously there are concerns that agitation and impulsivity associated with SSRIs could enhance the risks of suicidal or even homicidal behaviour.[11]

Formally,[12] there are no differences between the several licensed SSRIs in terms of their effectiveness as treatments for depression. As long ago as 1962 one of the early (non selective) reuptake inhibitors, imipramine, was shown to be effective in reducing panic attacks and ameliorating related agoraphobia.[13] Although reuptake inhibitors and MAOIs are generally referred to as antidepressants, right from their first introduction they have been used for and evaluated in the treatment of a much wider range of conditions. Thus, 'antidepressants' are also used in the treatment of a variety of anxiety disorders, obsessive–compulsive disorder (OCD), eating disorders, personality disorder and chronic psychoses where persistently low mood is a feature. As a result there are now a number of niche uses of SSRIs such as escitalopram for the treatment of panic attacks, or sertraline and fluvoxamine for the treatment of OCD in children. Furthermore, the practice of prescribing an 'antidepressant' for a wide range of disorders, which include those that

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[11] In 1989, Joseph Wesbecker shot dead eight people and injured 12 others before killing himself at his place of work in Kentucky. He had been taking fluoxetine for four weeks before this. Events led to legal action against its makers, Eli Lilly. A court ruled in favour of the plaintiffs. Healy et al. (2006) document nine cases in which homicide may well have been associated with prescribed SSRIs. There is an established body of evidence that worsened suicidal thoughts and behaviour can also be associated with SSRIs (Healy and Whitaker, 2003; Jick et al., 2004), and this has contributed to restrictions on the prescribing of them to young people.

[12] Evaluations of their effects when compared with one another or inert (placebo) treatments by clinical trial.

[13] Early enthusiasm for the therapeutic potential of psychopharmaceuticals in an environment dominated by large populations of asylum inmates led to the widespread trialling of their use across a wide range of conditions. In one such trial Klein and Fink (1962) detected efficacy of the early antidepressant imipramine amongst patients with recurrent panic attacks.

are very clearly 'anxiety' disorders, has blurred the distinction between 'anxiety' and 'depression' in the minds of patients and prescribers alike. This has led to the use of 'depression' as a term referring to all sorts of emotional and/or psychological distress, and has encouraged the use of antidepressants in response to situations as widely different and barely medical as bereavement and domestic violence. Finally, the epidemic rise in SSRI prescribing of the last 20 years,[14] which has been fuelled by nonspecific uses such as these, has resulted in large numbers of people who were given them for self-limiting states of distress. Many have fallen prey to the trap of believing that their recovery was due to medication that probably didn't really make any contribution to the outcome, but which they now believe to be necessary for their continued well-being.

Tricyclic Antidepressants

TCAs are the forerunners of the SSRIs,[15] dating from the first introduction of an antidepressant, imipramine, in 1955. Other TCAs still in use include amitriptyline, clomipramine, dosulepin hydrochloride, lofepramine and nortriptyline. In common with the SSRIs, their therapeutic potential is attributed to noradrenaline and serotonin reuptake inhibition, although there is no certain knowledge that this is how they work. They differ from the SSRIs in that they are far more sedating and they have chemical similarities with some antipsychotic agents. They also interfere with neurotransmission mediated by acetyl choline.[16] This has effects upon heart rate and rhythm, blood pressure, gut and bowels, urinary retention, salivation, sweating and visual accommodation. Their effects upon the heart make them particularly dangerous in overdose, and this was the main reported reason for their replacement with the SSRIs.

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[14] The annual number of prescriptions for antidepressants, largely SSRIs, in the UK rose from some 9 million in 1991 to more than 50 million in 2013.

[15] So called after their three, six-carbon ring chemical structure. In fact, this is not exclusive to the TCAs. Chlorpromazine has a similar basic structure.

[16] Acetyl choline is another neurotransmitter widely distributed in the brain. Owing to its prominent role in the workings of the parasympathetic autonomic nervous system, it also plays a significant part in the regulation of heart and blood vessels, gut, salivation, the urinary tract and visual accommodation. Acetyl choline is also involved in transmitting messages to muscle but the particular receptors responsible for this (nicotinic) are different from those (muscarinic) found in the autonomic nervous system and the brain, and it is muscarinic acetylcholine receptors that TCAs interact with.

Monoamine Oxidase Inhibitors

MAOIs that are currently in use include phenelzine, isocarboxazid tranylcypromine and moclobemide. By interfering with the enzyme monoamine oxidase they inhibit the breakdown of noradrenaline and serotonin, thus increasing the strength of their actions in the synapse. With the exception of moclobemide this effect is irreversible and only wears off slowly, as new monoamine oxidase is synthesised. Irreversible monoamine oxidase inhibition is dangerous because the enzyme also protects the body from related monoamines in the diet. Monoamine oxidase is present in the gut where it breaks down dietary monoamines, in particular tyramine. If tyramine gets into the circulation it can cause a hypertensive crisis.[17] To protect against this, those taking a MAOI have to accept dietary restrictions that limit the risk of ingesting tyramine, found in significant quantities in blue cheese, pickled fish, some red wines and certain other foods.

Other Antidepressants

Formularies include a small number of antidepressants that do not easily fall into these three categories. Venlafaxine and duloxetine are noradrenaline and serotonin reuptake inhibitors that do not interfere with acetyl choline to the same degree as the TCAs, and are known as selective noradrenaline and serotonin reuptake inhibitors. Mirtazepine and reboxetine are understood to increase synaptic levels of noradrenaline by interfering with a feedback loop that normally limits its release, and L-tryptophan is the naturally occurring precursor involved in the synthesis of serotonin. Trazodone has complex effects upon serotonin and noradrenaline neurotransmission, which include both enhancement and blockade. It has acquired a reputation for efficacy in the treatment of depression where anxiety and agitation are also prominent.

All of these have their adherents amongst prescribers and patients alike but, as with the SSRIs, TCAs and MAOIs, there are no clinical trial data formally supporting superiority of one over another in the treatment of depression or scientific data that clarify with any certainty how they work, when they do.

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[17] Tyramine causes the release of noradrenaline from nerve cells making up part of the autonomic nervous system which, amongst other things, regulates blood pressure.

Antipsychotic Agents

Antipsychotics are medicines whose primary purpose is a part in the management of psychoses. They are used because they have been found to reduce the experience of hallucinations, troubling delusions and associated distress. Antipsychotic agents are also known as neuroleptics and as major tranquillisers, and, in practice, their use extends well beyond the treatment of clearly psychotic states. These additional uses span control of disturbed behaviour in situations as widely different from one another as the elderly care home and the secure psychiatric unit. Furthermore, some medicines originally promoted as antipsychotic agents have now acquired a licence for use as mood stabilising agents.[18] Reflecting the fact that circumstances possibly calling for the use of an antipsychotic agent include those where coercion might be necessary, or patients might be considered insufficiently reliable to take tablets regularly, many antipsychotic agents are also available as a long-acting injection (depot preparation) or oro-dispersible (melt and absorbed in the mouth) forms, as well as conventional tablets and capsules. Depot preparations allow for medication to be overseen and administered fortnightly, sometimes weekly, sometimes less frequently. Oro-dispersible preparations allow effective oversight of patients' tablet taking. A common practice amongst reluctant tablet takers is to hide tablets in the mouth (mouthing) instead of swallowing them, until there is an opportunity to spit them out again. Using an oro-dispersible preparation, an overseer can keep the patient under observation for the few minutes it takes for the drug to be absorbed into the circulation without the need for swallowing.

The first antipsychotic to come into use was chlorpromazine, marketed from 1953 as Thorazine® in the USA and Largactil® in the UK. It had been synthesised in the course of searches for new antihistamines and from the outset its tranquillising properties were promoted as prominently as its so-called antipsychotic properties.[19] It remains

[18] Antipsychotic agents that are licensed as mood stabilisers include aripiprazole, olanzepine and quetiapine.

[19] An early 1960s trade advertisement for Thorazine® reads 'At the outset of treatment Thorazine's combination of sedative and antipsychotic effects provides both emotional and physical calming. Assaultive or destructive behaviour is rapidly controlled. As therapy continues, the initial sedative effect gradually disappears. But the antipsychotic effect continues, helping to dispel or modify hallucinations, delusions and confusion, while keeping the patient calm and approachable'. Available at: http://upload.wikimedia.org/wikipedia/commons/c/c2/Thorazine_advert.jpg (last accessed 4 January 2015).

unclear whether the helpful effects of antipsychotic agents are because they have a specific effect upon neurotransmitters implicated in psychosis or because they produce a peculiar and sometimes useful form of tranquillisation. Conventional medical teaching is that antipsychotic agents work because they inhibit dopamine-mediated neurotransmission (Gelder et al., 2009, p. 1209; McPhee, 2013, p. 98), the so-called dopamine hypothesis.

Theories of Antipsychotic Action: The Dopamine Hypothesis

The three lines of evidence that support the dopamine hypothesis of schizophrenia and other psychoses are (i) similarities between their effects and features of Parkinson's disease; (ii) similarities between psychosis and some of the effects of cocaine and amphetamine; and (iii) the observation that the more effectively a drug interferes with dopamine-mediated neurotransmission in the laboratory, the less of it is needed to suppress features of psychosis.

Early experience with chlorpromazine and related compounds revealed that they can cause muscular spasms and other movement abnormalities similar to those found in Parkinson's syndrome. These effects were not seen with other sedatives that were available at the time, such as barbiturates. A view developed that the antipsychotic effect was due to induction of a neurological state familiar to doctors as postencephalitic parkinsonism,[20] and indeed this is the origin of the antipsychotics' other class name, neuroleptic.[21] It was during this time that Parkinson's disease itself was found to be due to degeneration of dopamine-releasing nerve cells in the brain, and that dopamine replacement therapy was a dramatically effective treatment for it.[22] Thus, there were compelling connections

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[20] This is first attributed to the French psychiatrist, Pierre Deniker (1960) but the idea was taken up in Germany, where Hans-Joachim Hasse developed a measure of handwriting impairment (impaired handwriting is one of the hallmarks of parkinsonism) and argued that a 20% reduction in handwriting size was evidence of a sufficiently high level of 'neuroplegia' to signal an antipsychotic effect (Haase and Janssen, 1965), in the USA (Freyhan, 1959), in Canada (Denham and Carrick, 1960) and in England (Sarwer-Foner, 1960).

[21] Greek, 'neuroplegic', nervous paralysis.

[22] Based upon post-mortem studies of brains from people with Parkinson's disease, post-encephalitic parkinsonism (due to tissue damage caused by a viral infection of the brain (viral encephalitis)) and other degenerative brain conditions (Hornykiewicz, 1966). Soon afterwards there was clear evidence of improvement in Parkinson's disease with a specific dopamine analogue (Cotzias et al., 1969).

between the part dopamine plays in Parkinson's disease and the development of a condition similar to it when medicines subsequently described as antipsychotics were used as sedatives. At the time it was a short step from such connections to the attractive view that psychosis itself must be due to excessive dopamine activity. Hindsight has shown this to have been a naïve oversimplification.

Excessive or prolonged use of amphetamine or cocaine can cause psychosis, and this can be suppressed by antipsychotic agents. Amphetamine and cocaine promote the release of noradrenaline, serotonin and dopamine, and so the arousal they cause could be attributed to one or more of each of these. However, in addition to a psychotic state of mind in human users, amphetamine can also cause repetitive movements or stereotypies, which can be induced in laboratory animals. This has allowed extensive research, which has identified such stereotypies with excessive dopamine. For instance, such stereotypies are less readily reversed by sedatives such as barbiturates and benzodiazepines that do not act directly upon dopamine, than they are by traditional antipsychotic agents that do. Furthermore, although these stereotypies are not psychosis as experienced by troubled humans, they do provide a more practical laboratory assay for putative antipsychotic effects, and, as a result, they have played an important part in laboratory screening tests.[23] Thus, for many years a medicine was considered a putative antipsychotic for the rather circular reason that it was able to inhibit animal behaviours considered to be caused by excessive dopamine activity. Overall, there is some evidence that dopamine mediates stimulant-induced stereotypy and possibly hyperactivity, but other neurotransmitters are undoubtedly involved.

The mid-1970s saw publication of a close correlation between the affinity different antipsychotic agents have for dopamine receptors and the dose needed to alleviate symptoms. Affinity is a measure of how strongly a drug binds to a given receptor. Receptor-blocking drugs bind to one or more receptors in ways that mimic the naturally

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[23] After prolonged exposure to amphetamine, abnormally obsessive and repetitive behaviours can develop such as futile tinkering with mechanical equipment, sorting, tidying or grooming. Historically, these behaviours have been associated with excessive dopamine activity (Randrup and Munkyard, 1967). Similar 'stereotypies' can be induced in laboratory animals, and they have been available and have played a central role in laboratory screening tests for putative antipsychotic agents (Baumeister and Francis, 2002).

occurring neurotransmitter, but rather than activating the receptor in the way the naturally occurring transmitter would, they block access to the receptor, prevent binding by the naturally occurring neurotransmitter and inhibit its activation of the 'downstream' nerve cell. In broad terms, the stronger the drug's affinity for a particular receptor, the more effectively this happens. Relative affinity is a measure of how well one drug binds to a receptor in comparison to another. By 1976 there were a number of licensed antipsychotic agents in use, with varying levels of affinity for dopamine receptors, and in that year *Nature* published a striking relationship between the affinity of different antipsychotic agents for dopamine receptors and the dose generally in use for the treatment of schizophrenia (Seeman et al., 1976). Some 17 different antipsychotic agents that were then in regular clinical use were considered. The paper illustrated a very tight correlation between the affinity of these different medicines for dopamine receptors and the dose regularly used in the treatment of psychosis. The higher a drug's affinity for dopamine receptors the lower the regular dose when that drug was used therapeutically, and vice versa. In the same year, *Schizophrenia Bulletin* published an extensive review of the dopamine hypothesis of schizophrenia, which includes these and related findings as support (Meltzer and Stahl, 1976). This is despite the fact that the association was with the drugs' relative affinities to another drug, haloperidol, rather than relative affinity when compared with dopamine itself, and that the receptors in question were prepared from ground up parts of calf and rat brain. Relative affinities compared with dopamine were reported but were not as strikingly clear as the haloperidol data. The authoritative standard psychiatry textbook, *New Oxford Textbook of Psychiatry*, cites this review, in its second edition, which was published in 2009, as support for the statement: 'There is abundant evidence that dopamine plays a key role in the aetiology of psychosis and the action of antipsychotic drugs' (Gelder et al., 2009, p. 1210). Undergraduate lecture notes adopt a more conservative view: 'it is important to recognise that although the "dopamine hypothesis" might help to explain some of the therapeutic effects of antipsychotics, it does not in itself explain the pathophysiology of schizophrenia' (McPhee, 2013, p. 98). Over the years, considerable effort and resources have been invested in attempting to further clarify the dopamine hypothesis of schizophrenia and psychosis, but with little real progress. That is partly because

technical advances have revealed an increasingly complex picture,[24] and partly because a new therapeutic fashion has overtaken the original, dopamine-targeted antipsychotic agents.

First- and Second-generation Antipsychotic Agents

One of the most distressing experiences of psychiatric practice is the occasional encounter with someone suffering severe tardive dyskinesia. Tardive dyskinesia is a disorder of muscular coordination characterised by involuntary, writhing movements of the mouth and face, hands and arms, legs, and, when most severe, the torso. It is recognised as the result of permanent and irreversible changes in dopamine neurotransmission caused by prolonged antipsychotic use. Drugs that have an effect upon neurotransmission can and commonly do block or facilitate the action of neurotransmitters, and also change the numbers and sensitivities of the receptors they bind with. As a result, they can cause long-term changes in nerve cell connectivity. Tardive dyskinesia is understood to be the result of such changes to dopamine receptors as a result of long-term exposure to antipsychotic agents. It is irreversible and what is so distressing about it is that by the time it has developed many of the afflicted will have moved on from any serious disability or limitation attributable to their mental health difficulties, only to become disabled and limited by an equally if not more disturbing set of difficulties clearly due to the drug treatment they have been obliged to accept. Tardive dyskinesia can cause problems with talking and eating, holding things steady, walking, and driving and cycling, and someone afflicted by facial grimacing and writhing movements can be disconcerting company. There are reports that it is also associated with its own form of mental impairment.[25] The

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[24] For instance, some five different types of dopamine receptor have now been identified. All bind with dopamine but they can be distinguished on the basis of their affinity for other compounds. Different areas of the brain have different densities of dopamine receptor type, perhaps reflecting different functions. Type D_2 are the dopamine receptors considered most associated with antipsychotic effects but there is no incontrovertible evidence that their number, sensitivity or distribution are abnormal in schizophrenia or other forms of psychosis, and indeed there are strong suspicions that where increases in D_2 receptors have been observed in the brains of people with psychosis these are attributable to them having taken medication.

[25] One review, which considered 29 studies of tardive dyskinesia, found evidence of difficulties with memory, planning, organisational abilities and abstraction amongst referred patients in 23 of them (Waddington et al., 1993).

antipsychotic agents most closely associated with the development of tardive dyskinesia are those such as haloperidol, which have higher affinity for dopamine, D_2 receptors. There is no longer any doubt that when it develops in someone who has been taking antipsychotic medication, tardive dyskinesia is an untoward, long-term drug side effect. It is a particularly distressing disability, especially when it has to be accepted as permanent, has come as a further barrier to full recovery in someone who may have been beginning to emerge from their mental health difficulties and is due to medication that may well have been taken unwillingly.

The pursuit of drug treatments for psychosis that do not risk the development of tardive dyskinesia has resulted in a second wave of antipsychotic agents that are not so specifically targeted at the dopamine D_2 receptor. One of the earliest psychopharmaceuticals was clozapine, a drug that had similar effects to chlorpromazine. It was established as an antipsychotic and by the early 1970s it was in use in many parts of Europe. In 1975 there were reports that it could cause life-threatening immunological problems,[26] and its use rapidly fell away. Nevertheless, carefully monitored use continued, and in 1988 clozapine was reported to be more effective than the conventional, dopamine-targeting antipsychotic haloperidol in 'treatment resistant schizophrenics' (Kane et al., 1988). By the early 1990s several new antipsychotic agents had been introduced, which were based upon clozapine but which did not have its reputation for causing immunological problems. The first amongst these were olanzepine, risperidone and quetiapine, and, more recently, ariprazole, amisulpride and paliperidone have joined the list. To distinguish these from earlier antipsychotic agents such as chlorpromazine, flupentixol, haloperidol, sulpiride and zulclopenthixol, the later agents have become known as atypical or second-generation antipsychotic agents, and the earlier ones as typical or first-generation compounds. Rather than being promoted as agents that correct abnormally active dopamine neurotransmission, which was the rationale behind the first generation of antipsychotics, second-generation antipsychotics are attributed a wide range of therapeutic mechanisms, reflecting their complex pharmacological properties.[27] Second-generation antipsychotic

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[26] Clozapine-associated agranulocytosis was first reported in *The Lancet* in 1975 (Idanpaan-Heihhila et al., 1975).

[27] Olanzepine, for instance, is reputed to have moderate-to-high affinity for four different types of dopamine receptor, five different types of serotonin receptor, two different types of noradrenaline receptor, two different types of acetylcholine receptor and one histamine receptor, along with weaker affinities for others.

agents are claimed to carry a lower risk of tardive dyskinesia than their predecessors. They are equally effective when evaluated as treatments for psychosis,[28] and their complex pharmacology brings with it a different range of side effects and possible long-term consequences. Furthermore, because they are not so narrowly identified with an assumed target abnormality deemed specific to a particular condition (dopamine abnormalities in psychosis) the way has been clear for them to be developed for a wider range of conditions. Olanzepine, quetiapine and aripirazole are licensed for use as mood stabilisers in the treatment of bipolar disorder, and all three are now recommended as options in the treatment of depression. All antipsychotic agents are sedating and so they are attractive in situations that call for the quietening of disturbed behaviour, particularly distressing anxiety or agitation. Thus, drugs initially introduced as improvements upon earlier approaches to the correction of abnormal brain chemistry believed to cause schizophrenia are now in use as nonspecific treatments for the full range of psychoses, bipolar disorder, depression, anxiety and other forms of disturbed behaviour. In England, the number of prescriptions for antipsychotic agents rose from 4.7 million in 1998 to 7.5 million in 2010.[29] Although they do not cause tardive dyskinesia as readily as their predecessors, second-generation antipsychotic agents still come with a range of troubling side effects and the full implications of this explosion in their use have yet to be realised.

The list of side effects is a long one. In common with antidepressants, both classes of antipsychotic agents can cause sexual dysfunction, in particular erectile impotence in men. Women are susceptible to galactorrhoea (excessive breast milk) and menstrual disturbances, primarily because the drugs stimulate the release of prolactin, which is a hormone that plays a part in regulating lactation. Both classes can cause heart rate irregularities, disturbances of blood pressure regulation and weight gain but perhaps of greatest longer-term concern should be the propensity second-generation antipsychotics appear have to influence fat and sugar metabolism. Although weight gain and impaired

[28] Two major trials making direct comparisons between first- and second-generation antipsychotic agents were conducted in the USA and the UK during early years of the twenty-first century (Lieberman et al., 2005; Jones et al., 2006).
[29] Data obtained from the National Health Service Information Service (Ilyas and Moncrieff, 2012).

glucose tolerance were observed with first-generation antipsychotics,[30] they are a source of greater concern in relation to second-generation ones. Olanzapine and clozapine are strongly linked to impaired glucose tolerance and diabetes; risperidone and quetiapine significantly but less so (Taylor et al., 2012, pp. 132–3). It now appears that this interference with glucose metabolism is part of a wider metabolic disturbance, which includes increased levels of harmful fats such as cholesterol (Rummel-Kluge et al., 2010; Smith et al., 2010; Chaggar et al., 2011). Diabetes and other causes of abnormal lipid metabolism are well established risk factors for heart disease, stroke and premature death, and there is already evidence that the metabolic syndrome associated with second-generation antipsychotic agents is having these effects (Correll et al., 2006). Although the introduction of second-generation antipsychotic agents has removed some of the risk of tardive dyskinesia, it has introduced the risk of other serious longer-term consequences. Also, by adopting a much wider and less disease-oriented approach to the pharmacology of 'antipsychotics', it has licensed their use across the full range of mental health difficulties, exposing an ever increasing number of people to those risks, while, at the same time, quietly abandoning the view that psychoses, and schizophrenia, in particular, can be usefully understood as an identifiable disturbance of brain chemistry.

Antimanic and Mood-stabilising Agents

The acute disturbance of mental state known as mania or, when of a lesser degree, hypomania, is a distressing situation in which the afflicted is overexcited and can be threatening, act in irresponsible ways such as injudicious spending or promiscuity, and is commonly a source of considerable distress to those around them. Prior to the era of psychopharmaceuticals such situations were managed with the sedatives that were available at the time (e.g. chloral hydrate or barbiturates), confinement or electroconvulsive treatment. Periods of hypomania are commonly self-limiting, and tend to be followed by periods of remorse and withdrawal. This alternating pattern of elation and depression has been recognised for a long time and was

[30] Glucose tolerance is a measure of the readiness with which glucose sugar is taken up from the blood into muscles and other tissues. The ease with which this happens reflects the availability and effectiveness of the hormone insulin, which are both reduced in diabetes. Glucose intolerance, poor uptake from the blood is a central feature of type 1 and type 2 diabetes. Poor glucose intolerance is one feature of the metabolic disturbances that are diabetes.

originally known as manic depression. In parallel with conceptualisation of depression as a disturbance of mood regulation, manic depression has become known as bipolar affective disorder and for 50 years or so therapeutic focus has been upon finding and using medicines that can limit the swings of mood, which are considered its core feature. The first of these to come into use was lithium carbonate. That has been followed by the use of medicines initially developed for the treatment of epilepsy, such as sodium valproate, and most recently by the widening of licensed uses for second-generation antipsychotic agents to include the treatment of bipolar disorder. This widened use of second-generation antipsychotic agents has been accompanied by a relaxation of diagnostic criteria for bipolar disorder to include a much wider range of conditions and individuals who might, possibly, benefit from them,[31] although almost all of the research on drug treatment has been conducted with people suffering the classic and most severe form of the condition (see Moncrieff, 2014).

Lithium carbonate was introduced as a treatment for manic depression in the early 1950s, although it was not until the late 1960s that the practice acquired popularity. Lithium citrate is a liquid preparation available for those who find the tablets difficult to swallow or in situations where 'mouthing' and spitting out is a concern. There is no consensus about how it works or what the basis of its therapeutic properties might be.[32] In the absence of a credible hypothesis for its use as a

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[31] Classic bipolar disorder or manic depression (bipolar 1) is a condition in which the afflicted has suffered from an episode of elevated mood lasting at least seven days and during which experienced psychotic phenomena such as delusions, hallucinations or disordered thinking, and has also suffered episodes of depression. Bipolar 2 is a condition in which the index episode of elevated mood is one in which the identifying feature is elevated mood itself, of four days' duration, with no need for corroborating psychotic features. This is difficult to distinguish from a 'naturally occurring' period of elation or enhanced well-being, and it opens the opportunity for identifying many forms and instances of mood fluctuation as bipolar disorder (Gelder et al., 2009, p. 643). Fewer than 1 in 1,000 people were hospitalised on account of a typical episode of mania during the twentieth century (Healy, 2008), and formal epidemiology conducted during the early 1990s identified 1.3% of the US population to be suffering from bipolar 1 (Kessler et al., 1994). In 2003, 11% were said to be suffering bipolar 2, and 24% some form of disturbance on the 'bipolar spectrum' (Angst et al., 2003).

[32] Dissolved lithium is an elemental ion handled physiologically in just the same way as the ubiquitous sodium ion. Laboratory studies have shown an effect upon intracellular sodium-dependent second messenger systems, which might influence serotonin and noradrenaline transport, but all explanations remain speculative and there is no leading hypothesis (Marmol, 2008).

mood stabiliser the story of lithium's medicinal journey from the treatment of gout in the nineteenth century, as a tonic added to beers and soft drinks early in the twentieth century, and later as a salt substitute is an intriguing one of personal promotion, public fashion and hope, well told elsewhere. One of the consequences has been consolidation of professional and popular views, that 'mood' is something that can be chemically 'stabilised'.[33]

In excess, lithium is toxic and its safe use in substantial doses only became possible when blood levels could be easily monitored. Minor degrees of lithium toxicity include nausea, diarrhoea, muscular weakness and tremor.[34] If and when blood levels rise further disorientation, seizures, coma and death can follow. Standard recommendations are a blood level of between 0.4 and 1.0 mmol/l (British National Formulary, 2013, p. 241), and this is achieved by regular blood test monitoring. As lithium circulates in the body in the form of an ion excreted by the kidneys toxicity is a particular risk during times of dehydration such as an acute febrile illness, vomiting or diarrhoea, or prolonged exercise in a warm climate. Those taking it under such circumstances have to pay particular attention to hydration and blood levels. Irrespective of blood levels, lithium can be associated with an unpleasant metallic taste. Some skin conditions can be aggravated, and it can lead to weight gain. It is also associated with thyroid and kidney problems. Lithium can interfere with the release of thyroxine,[35] and can cause long-term kidney damage.[36] Monitoring should include regular thyroid and kidney function tests. Finally, lithium is associated with congenital heart defects in children of women taking it when pregnant, and it has to be stopped if pregnancy occurs or is intended.

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[33] In *The Myth of the Chemical Cure*, Joanna Moncrieff provides an entertaining and scholarly account of lithium's journey to, and its current incarnation as, the archetypal mood stabiliser (2009, pp. 174–203).

[34] Some toxicity is predictable with a blood level of 1.5 mmol/l or more.

[35] Thyroxine is a hormone produced by and released from the thyroid gland situated in the neck, which serves to regulate a wide range of metabolic processes. Thyroid deficiency leads to a slowing of metabolism, reduction in energy levels, weight gain, heart failure and other problems. One study reported a 20% risk of this developing in middle-aged women taking lithium (Johnston and Eagles, 1999). Once detected, thyroid deficiency is readily corrected by taking artificial thyroxine as a replacement.

[36] In one study (Bassilos et al., 2008), a third of young people who had been prescribed lithium had a significantly reduced glomerular filtration rate (a standard measure of kidney function).

Not only is it difficult to understand how and why it works, lithium is risky to use and involves intrusive, regular blood tests. Thus, it is unsurprising that other medicines' qualities as 'mood stabilisers' have been explored.

The first of these are drugs initially introduced for the treatment of epilepsy. When benzodiazepines were introduced in the 1960s it became apparent that they were effective in controlling epileptic fits but they were not considered suitable in the routine treatment of epilepsy because of the sedation they cause at the doses this requires. Nevertheless, the search for effective antiepileptics has included development of drugs which act in similar ways,[37] and it has resulted in the widely used antiepileptic agents sodium valproate, carbamazepine and lamotrigine. During the latter years of the twentieth century these and their derivatives were also investigated for their 'mood stabilising' properties,[38] and have become licensed for that use, even though the concept of 'mood stabiliser' is vague and poorly defined (see Moncrieff, 2014). Despite the fact that they show little or no therapeutic advantages over lithium,[39] their relative safety and the absence of a need for regular blood tests has made them popular 'mood stabilising' agents. That is not to say they are without their own untoward effects. All are sedating. Valproate can cause lethargy, tremor, confusion and hair loss, and it, too, is associated with congenital defects if taken during pregnancy (Taylor et al., 2012, p. 155). The UK recommendation is that it should not be taken by women of childbearing age (National Institute for Health and Clinical Evidence, 2006). The main side effects associated with carbamazepine are dizziness, double vision, drowsiness, difficulties with gait, sexual dysfunction, nausea and headaches and confusion, and it is also associated with congenital abnormalities. Formal advice is to avoid it where they may be a possibility of pregnancy (Taylor et al., 2012, pp. 169–70). Lamotrigine shares many of these side effects and

[37] The neuroinhibitory effect of GABA, which is potentiated by benzodiazepines, is considered to be due to a stabilising effect upon nerve cells membranes, which makes them less susceptible to excitation. Sodium valproate, carbamazepine and lamotrigine all share this property.

[38] Valproate, as Depakote®, semisodium valproate was approved by the US Food and Drug Administration for the treatment of acute mania in 1993 and its use as maintenance therapy; approval in the UK soon followed. Lamotrigine was approved as a maintenance treatment for bipolar disorder in 2003 (Weisler, 2008) and carbamazepine after a trial published in 2004 (Weisler et al., 2004).

[39] Trials in UK and Denmark (Geddes et al., 2010; Kessing et al., 2011).

may be associated with cleft palate in children born to women taking it when pregnant (ibid, p. 440).

Antipsychotic agents are effective tranquillisers and the use of first-generation antipsychotic agents in the management of acute mania and hypomania was well established before the second-generation antipsychotic agents were introduced. As they did become available, second-generation antipsychotic agents began to be used for the same purposes, proved equally effective, and with a conceptual blurring of distinctions between the quietening of acutely disturbed behaviour and 'mood stabilising', they too became candidates for the longer-term management of bipolar disorder. Olanzepine, quetiapine, aripirazole and risperidone have all acquired formal regulatory approval for this following controversial discontinuation studies, and, with it, reputations as 'mood stabilisers'. Given concerns about the toxicity of their predecessors, lithium, valproate, carbamazepine and lamotrigine, and the fluidity the concept 'mood stabiliser' has won, they are set to be made available to many who wish to ameliorate unwelcome mood swings,[40] despite the fact that they have never been shown to be effective in this way (see Moncrieff, 2014), and that they, too, come with their own potentially catastrophic side effects.[41]

Over the last half century the drug treatment of bipolar disorder, formerly known as manic depression, has evolved from the use of sedatives to calm overexcited individuals into the development of a concept, 'mood disorder', which can be alleviated by medicines that act as 'mood stabilisers'. These are very attractive prospects amongst those seeking a quick fix for unwelcome feelings, but this has to be understood as as much a lifestyle modification as it might be a formal medical treatment. The journey from sedation to chemical mood stabilisation is without any clear scientific basis, and if and when it is travelled to its conclusion, it involves the use of medicines with a wide range of quite serious short- and long-term side effects for a variety of ethically questionable reasons.

Stimulants and Drugs used for Attention Deficit Hyperactivity Disorder

Amphetamine and methylphenidate have been in use since the 1930s, and during the 1940s and 1950s they were widely used to treat

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[40] In *The Bitterest Pills*, Joanna Moncrieff gives a fuller account of the ways in which the concept 'mood stabiliser' has been developed and applied to second-generation antipsychotic agents (2013, pp. 189–207).

[41] Risks of diabetes, heart disease and stroke (Correll et al., 2006).

depression. Concerns about the potential for abuse, dependency and the rise of alternative drug treatments led to a fall in their popularity, but their use in children has continued. Indeed, in recent years it has mushroomed and this availability has become a significant source of drugs also used for recreational and lifestyle reasons.

As already noted, amphetamine promotes the release of noradrenaline, serotonin and dopamine from nerve cells that use these as their neurotransmitter. Much of the noradrenaline, serotonin and dopamine in the brain comes from nerves cells that make up what might be considered mechanisms of arousal and so it is understandable that drugs that have these effects influence arousal and cause stimulation. One of the fundamentals of experimental psychology is the Yerkes–Dodson Law,[42] which identifies a relationship between arousal and performance on a variety of tasks. Too little arousal and performance is impaired. Too much and the same happens, albeit in different ways. Optimal performance is associated with an optimal level of arousal, and so it is barely surprising that at the right dose and under the right circumstances drugs that promote the release of noradrenaline, serotonin and/or dopamine can improve psychological performance. Low levels of arousal include poor attention and distractibility. Unduly high levels of arousal include hyperactivity and difficulties fixing upon any one task. Thus, one of the features of optimal arousal is an appropriate level of fixed attention. Caffeine, the world's most widely used psychoactive agent, acts as a stimulant with some similarities to amphetamine and methylphenidate, and its popularity is largely owing to its ability to improve concentration.

The notion that some children are different and suffer abnormalities of arousal that can be corrected by the use of medicines derived from observations that in some cases children's attention, behaviour and school performance could be improved by the use of stimulants such as amphetamine and methylphenidate. This appeared to contrast with the debilitating effects found in adults using the same drugs as intoxicants, and has led to the view that some children are neurochemically different and indeed may be afflicted by a persistent abnormality. This is not the place to go into the detail of debate that surrounds whether or not that might be the case, but it is widely accepted as inconclusive. What is generally agreed is that the apparent paradox of improved performance in some children when taking drugs that impair adult

[42] First described by Robert Yerkes and John Dodson in 1908.

performance is owing to the fact that doses given to children in these circumstances are much lower for their body weight than doses used by adults for intoxication. In animal models and adult humans low doses of stimulant reduce activity and focus attention in just the same way as in children prescribed for attention hyperactivity deficit disorder (ADHD).[43] In the absence of clear evidence that such children differ from others in a chemically definable way, the effects of stimulants upon them could be nothing more than the helpful effect of a stimulant upon otherwise reduced arousal. It might be helpful to improve children's attention in this way, but the fact that this is possible does not in itself demonstrate that their prior poor attention was due to a chemical deficit. This has not stopped many millions of prescriptions for ADHD medications being written every year in the US and in the UK, the distraction of many children and their parents from the everyday realities of growing up by the view that some of their particular difficulties might be due to a correctable abnormality, and inculcation in some of the view that this reflects a need for lifetime medication. Even if it is sometimes helpful to assist a particularly inattentive child for a short period of time there is no incontrovertible evidence that this reflects an enduring problem anymore than need for a strong cup of coffee at the beginning of the day might suggest the same in an otherwise healthy adult.

The most widely used stimulants are methylphenidate and atomoxetine. Amphetamine itself is sometimes prescribed when either or both of these seem to be ineffective. Methylphenidate is available in slow-release forms, which allow for once-daily dosing. Side effects of methylphenidate include abdominal pain, nausea and vomiting, heart rate irregularities and changes in blood pressure, irritability, aggression and movement disorders. It can impair growth. Taking atomoxetine can also cause abdominal and cardiovascular problems, sexual dysfunction, urinary retention and menstrual disturbances (British National Formulary, 2013, pp. 256–7). All have abuse potential, but what have yet to be established are the long-term consequences of widespread use amongst young, growing and developing people, which will only become apparent as the many young people now taking them move on through life.

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[43] Low doses of stimulants improve performance in animal models and higher doses impair through actions upon dopamine and noradrenaline activity in the frontal cortex (Arnsten and Dudley, 2005).

Drugs Used in the Treatment of the Addictions

The use of medication in the treatment of addictions is largely that of drugs that alleviate withdrawal symptoms, including some of the sedating anxiolytics outlined above, synthetic opiates such as methadone, and nicotine replacement. They mimic effects of the drug of addiction and can reduce the discomfort and desperation that accompany withdrawal. Disulfiram interferes with the natural breakdown of alcohol, resulting in an unpleasant reaction due to a build-up of acetaldehyde if alcohol is consumed, which makes drinking even the smallest quantity very unpleasant. Naltrexone is a medicine that interferes with natural opioid mechanisms and therefore with the pleasurable experiences of alcohol and other intoxicants. Acamprosate is a drug that is claimed to relieve cravings for alcohol. Its effects are uncertain and it is not widely used.

To Summarise

This précis of textbook psychopharmacology reveals a fine balance between scientific explanations of these drugs' actions and therapeutic effects, and their costs in terms of untoward physiological and psychological consequences. It does not weigh heavily in favour of the former. Given the full scale of scientific uncertainties associated with the use and development of medicines for psychiatric purposes, and the range and implications of their short- and long-term side effects, widespread use of psychopharmaceuticals for the treatment of 'mental health difficulties' is not and never has been a safe and scientifically sound enterprise. Despite this it has become the mainstay of modern practice. This reflects the success with which it was promoted during the second half of the twentieth century, and the apparently simple solution 'taking a pill' offers those troubled by what are, much more often, much more complex difficulties. Longer-term drug side effects, discomfort with what many see as cynical exploitation by those with interests in promoting psychopharmacology and the consequences of frustrated expectations when taking a pill doesn't fulfil them all contribute to frustrations with medical psychiatry's attachment to correcting abnormalities of brain chemistry. Such criticisms are now being voiced by the scientific community itself, as well as by a disaffected public. These criticisms will be addressed in Chapter 4, along with a more sophisticated and honest view of how psychopharmaceuticals might be exerting their effects when these do turn out to be helpful.

4
Psychopharmacology Reconsidered

The account of therapeutic psychopharmacology provided in Chapter 3 points to some serious gaps in knowledge and understanding. Anxiolytics are licensed and prescribed for the treatment of anxiety, not because they are known to influence clearly understood chemical pathways associated with anxiety, but because they are effective sedatives, in essence no different from alcohol. In some ways they might be safer but prescribed anxiolytics also carry a heavy risk of dependency and tolerance.[1] Antidepressants have been developed and marketed as such on the basis of their abilities to influence activity of the neurotransmitters noradrenaline and serotonin,[2] even though there is no widely acknowledged evidence that these are abnormal in depression. Recent years have seen the range of conditions for which antidepressants are licensed and prescribed broaden considerably, without any parallel growth in knowledge apart from clinical trials conducted with enlargement of the market for them in mind,[3] and antidepressants are now amongst the most widely prescribed medicines on the planet. In their earlier years antipsychotic agents were promoted on the basis of their ability to interfere with dopamine neurotransmission.[4] Concern about seriously disabling side effects attributable to this has led to

[1] For clarification of the term 'tolerance', see note 6, Chapter 3
[2] For clarification of the terms 'neurotransmitter', and 'noradrenaline' and 'serotonin', see notes 4 and 9, Chapter 3, respectively.
[3] There are many accounts of selective and possibly misleading drug trials reporting in this area. See, for instance, Healy (2002), Lewis (2006), Moncrieff (2009, 2013), Kirsch (2009) and Whitaker (2010).
[4] For clarification, see Chapter 3, section 'Theories of Antipsychotic Action: The Dopamine Hypothesis'.

the development of alternatives that no longer have that theoretical justification, however tenuous it was.[5] This separation from a theoretical framework has allowed the promotion of so-called antipsychotic agents for the treatment of a much wider range of conditions. The result is increasingly widespread use of drugs that have the potential to cause obesity, diabetes and heart disease. Recent years have also seen an explosion in the prescription of potentially dangerous and addictive stimulants to children and young adults, again without any substantive and generally agreed evidence of an underlying chemical abnormality that they may be correcting.

Desperate times call for desperate measures, and mental health difficulties are commonly experienced as pressing and distressing by all concerned. It is unsurprising that promises of treatment or relief from distress are readily taken up. There are undoubtedly circumstances in which it would be inhuman or improper not to use a tranquilliser, for instance when a seriously disturbed person is at immediate risk of harming themselves or others, or a sudden, unexpected and traumatic bereavement results in acute psychological distress, but these are relatively unusual circumstances. Furthermore, when medication is used to sedate such a person it is clear that that is what the medicine is being used for, and there is no need for recourse to the notion that it is being used to treat an illness. Clearly, psychopharmaceuticals are used far more widely than this and for a much more complex set of reasons than simply that of tiding someone over a brief period of intense distress. In popular imagination and in the minds of many who seek or prescribe them, psychopharmaceuticals are seen as scientifically proven and definitive treatments for a range of illnesses. This reflects the success with which that notion has been promoted during the second half of the twentieth century, and the understandable attractions the apparently simple solution of taking a pill offers those troubled by more complex difficulties. In recent years, mature reflection upon data gathered during this period and advances in basic neuroscience have tempered that view. Leading neuroscientists no longer seek biological explanations for mental illnesses as they are defined by the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Science itself is finding the human brain to be far more complex and adaptive than previously

[5] For clarification, see Chapter 3, section 'First- and Second-generation Antipsychotic Agents'.

thought, and in ways that make it difficult to manipulate in any direct and reliable way. More culturally sensitive, less paternalistic and more person-centred approaches to medical practice are revealing the importance of symbolic meanings embedded in the consultation and any resulting prescription. This offers an approach to psychopharmacology that is different from the medically framed approach centred on the treatment of distinct illnesses that has prevailed for the last half century. This chapter considers these fundamental difficulties with psychopharmacology and introduces a more honest appreciation of what is known about the use of such medicines and the psychological effects of prescribing them.

The National Institute of Mental Health and DSM-5

The National Institute of Mental Health (NIMH), which is based near Washington, DC, describes itself as the largest scientific organisation in the world dedicated to research focused on the understanding, treatment and prevention of mental illness.[6] It embodies a major investment and houses some of the world's leading neuroscientists. By the time the DSM-5 was published in May 2013, the NIMH had concluded that its research was no longer assisted by conventional classifications of mental illnesses and it would no longer use the DSM or the ICD as a framework.[7] The link between neuroscience research and the development of drug treatments targeted at specific mental health difficulties was broken.

All prescription-only medicines are explicitly licensed for use in the treatment of particular disorders, and any use beyond these licensed applications, so-called off-label prescribing, has to be regarded as irregular and only acceptable if it is clearly justified on a case-by-case basis. As mental health difficulties are formally classified by the DSM and ICD, licensed applications are obliged to be for the treatment of one or more DSM or ICD categories. In declaring that they were no longer framing their work around DSM criteria, leading neuroscientists have declared that they believe it more productive to focus upon understanding

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[6] See http://www.nimh.nih.gov

[7] In August 2008 the NIMH released a strategic plan in which emphasis is given to a much broader agenda than simply finding treatments for formally defined 'illnesses' (National Institute of Mental Health, 2008). When the DSM-5 was published in 2013, the Director of the NIMH publicly announced that his organisation would develop its own distinctly different 'Research Domain Criteria' (Konnikova, 2013).

the biological substrates of experimentally accessible psychological phenomena, rather than continuing to seek neurobiological, neurochemical and pharmacological explanations and drug treatments for schizophrenia, depression, bipolar affective disorder and other 'illnesses'.[8] It remains to be seen whether this will eventually result in different, less toxic and more effective drug treatments for mental health difficulties. What it does do is add scientific authority to longer-standing concerns about psychopharmacology. It also raises questions about the full honesty of current practices. Medicines continue to be promoted as antidepressants, antipsychotics, and treatments for depression, panic attacks, schizophrenia, bipolar disorder and other mental illnesses, even though this prominent shift in research policy suggests that such an approach has had its day.

Psychopharmacological Scepticism

There are longer-standing concerns about psychopharmacology that resonate with these leading scientists' rejection of claims that mental illnesses can be mapped onto chemical abnormalities susceptible to drug treatment. Over the years, these have found expression as scholarly and professional clinical review, polemics and the experiences of mental health service users.[9] Reference was made to these in the 'Introduction'. They include numerous accounts from individuals who have been caused to take toxic medicines, often unwillingly and sometimes with irreversibly disabling long-term consequences such as tardive dyskinesia. Many of these are distressing and reflect the suffering and oppression sometimes still often forced upon people with 'mental illness'. Polemics include a number of journalistic contributions where an important focus has been to reveal ways in which the pharmaceutical industry has exploited the commercial opportunities

[8] The Research Domain Criteria matrix outlines ten domains of basic neuroscience research, which include 'Positive and Negative Valence Systems', 'Perception', 'Working Memory', 'Affiliation and Attachment', and 'Arousal' (National Institute of Mental Health, 2011).

[9] This is a considerable literature that cannot be systematically reviewed here. Seminal contributions, which give a flavour of it, include Charles Medawar's and Anita Hardon's *Medicines Out of Control?* (2004), Daniel Carlat's *Unhinged* (2010), Richard Bentall's *Doctoring the Mind* (2009), Jim Read's *Psychiatric Drugs* (2009), Robert Whitaker's *Anatomy of an Epidemic,* Ethan Watters' *Crazy Like Us* (2010), James Davies' *Cracked* (2013) and China Mills' *Decolonizing Global Mental Health* (2014).

mental distress offers. Another has been the part played by academic psychiatry in nurturing the myth of a chemical cure in pursuit of scientific grandeur. These are important considerations, but they are best dealt with elsewhere, alongside other reflections upon the influences of organised interest groups within and upon psychiatry. Scholarly and clinical reviews draw attention to the frailty and internal contradictions of published scientific evidence in support of the 'chemical abnormality' thesis, and to alternative ways in which the undoubted effects of psychopharmaceuticals might be better understood and used. Most of these arguments can be distilled down to four considerations, which also reflect leading neuroscientists' concerns. The first is that the more science unravels brain chemistry, the more detailed and complex it proves to be. The second is that the sorts of difficulty that trouble people and form the basis of problems for which psychopharmacology might be a solution are not easily understood as chemically identifiable actions. The third is that because the brain is an adaptive set of systems, longer-term drug administration leads to longer-term adaptive changes that alter sensitivities and other properties of the nerves that drugs might act upon, with currently unpredictable effects. The fourth is that giving a medicine to someone is more than just a chemical event. The intervention has meaning. It is generally regarded as an acknowledgement of difficulties and a treatment provided by someone minded to help. As such, it is also a social act with effects of its own quite capable of interacting in complex ways with any chemical effects the medicine might also have.

The Complexity of 'Brain Chemistry'

A representative adult human brain has a volume of some 1.3 litres. It is estimated that the human cerebral cortex has 0.15 quadrillion synapses,[10] or connections between nerve cells (Pakkenberg and Gundersen, 1997). This works out at some 115,000,000 synapses in a cubic millimetre. Each synaptic connection between one nerve cell and another involves not only release of a neurotransmitter, but also complex interactions between the numbers and sensitivities of pre- and postsynaptic receptors, the clearance or breakdown of neurotransmitter, second messenger mechanisms within each nerve cell and other influences yet to be

[10] That part of the brain conventionally associated with sensory perception, information processing and 'thought'.

fully understood … 115,000,000 times in each cubic millimetre. One of psychopharmacology's challenges is to influence these complex and detailed processes without being able to address them directly. Even if it was acceptable to inject a drug directly into a particular part of the living human brain it is unlikely a target could be identified with anything much more than an accuracy of a cubic millimetre, and then which of the hundred million synapses inside it might be the right ones? Even if that was achieved, which of the several chemical processes each synapse entails should be the drug's site of action? As it is, we are far from injecting drugs directly into the brains of psychiatric patients and all that medicine can do is introduce one or more drugs into the fluid that bathes the whole brain by getting them into the circulation through digestion or injection into muscle or skin. Contrasts between the pharmacological clumsiness of taking a medicine by mouth or conventional injection and the remarkably fine detail of brain chemistry could not be starker, and it is barely surprising that psychopharmacology has yet to come up with any truly understandable effects other than sedation and stimulation. The chemical complexity of the human brain and the tools we have available to influence it are in entirely different leagues.

Psychological Phenomena are not 'Drug-specific'

Ways in which the use of any one class of psychiatric drugs has shifted from mental illness to mental illness are part of psychopharmacology's story. Second-generation antipsychotic agents are a good example. As described in Chapter 3, although these were introduced as improvements on earlier antipsychotics, several second-generation antipsychotics are now also promoted as mood stabilisers, antidepressants and sedatives. This contrasts with claims that they work because they correct specific abnormalities of brain chemistry peculiar to this, that or another mental illness. Weakness of linkages between an identifiable psychological problem and underpinning brain chemistry is well illustrated by the example of anxiety.

Undue anxiety is a common enough problem and a frequent reason for seeking medical help. The British National Formulary would offer a British doctor the choice of a benzodiazepine, a selective serotonin reuptake inhibitor (SSRI), a tricyclic antidepressant (TCA), a beta blocker or buspirone.[11] Although they probably wouldn't recommended any of

[11] See note 1, Chapter 3.

them in this situation, the doctor would also know that opiates, alcohol, barbiturates and cannabis could also relieve their patient's distress in the short term. Benzodiazepines, SSRIs, TCAs, beta blockers, buspirone, opiates, alcohol, barbiturates and cannabis all relieve anxiety but the range of chemical properties they represent is huge. Viewed from this perspective it is hard to see how anxiety can be identified with a clearly defined chemical footprint. The same has to be true for depression, psychotic experiences, obsessions or any of the other disturbed states of mind for which people seek the help of doctors.

'Brain Chemistry' and Psychopharmaceuticals are in Dynamic Interaction

One of the difficulties encountered after benzodiazepines had been in regular use for a few years was that their effects seemed to wear off, and that those taking them regularly suffered craving and worsened anxiety. They had developed tolerance and dependency in just the same way as those who become addicted to opiates, alcohol, cocaine or amphetamine. In part, tolerance and dependency reflect nerve cells' ability to adapt. In the presence of a drug that has an effect upon synaptic mechanisms, receptor sensitivities change, and their numbers rise or fall. There may be changes in rates of neurotransmitter clearance and there may be changes to second messenger processes within the cell. The synapse's conducting properties are changed to accommodate the fact that its normal activity has been disturbed by the action of a drug, and in the case of benzodiazepines, alcohol and opiates this is to compensate for drugs' effects, and shift the synapse back towards a predrug state of sensitivity. Adaptive changes such as these offer a way of understanding the need for increasing doses if the same effect is to be experienced. When the drug is withdrawn or stopped the synapse and other mechanisms will be unbalanced, with consequences that are largely unpredictable but which offer some explanation for withdrawal symptoms and craving. We now know that withdrawal symptoms are common after the medium- and long-term use of antidepressants and antipsychotic agents, and so it is highly likely similar adaptations are also associated with them. Drugs that influence neuronal mechanisms are acting upon some of the natural world's most delicate, sensitive and responsive processes. When introduced they do far more than simply correct a state of imbalance: they initiate a process of adaptive change with results that are still largely unpredictable, but clearly have implications for an understanding of longer-term effects.

The Meaning of Medication

Given so many reservations it might seem surprising that psychopharmaceuticals play such a central part in psychiatric practice, are so widely used and, for many who use them, effective relief from their troubles. This is clearly despite the fact that there is minimal understanding of what they actually do and little or no evidence for clear and agreed abnormalities of brain chemistry that might explain mental health difficulties and offer targets for corrective drug treatment. Nevertheless, many hundreds of clinical trials have been conducted proving that they work. Across the globe many hundreds of millions of people willing to take psychopharmaceuticals and presumably those who take them over a long period do so because they find it helpful. Most who prescribe them do so because they believe them to be effective and, in many instances, because they have seen them work with their own eyes. This paradox between, on the one hand, widely held, often powerful convictions that drug treatments are effective and are rightly placed in the centre of the psychiatrist's tool box, and, on the other, no substantial, relevant scientific advances across psychopharmacology's 50 or more years that explain this is one of psychiatry's big issues, if not the biggest. Those who promote them have amassed reams of data that support claims that drug treatments are effective. The notion of a readily available and effective drug treatment is very attractive to a troubled person or their associates, to busy doctors and to healthcare provider organisations. However, these medicines cause serious side effects and, particularly in the cases of second-generation antipsychotic agents and stimulants used for the treatment of attention deficit hyperactivity disorder and related conditions, the full costs of these have yet to be realised. Furthermore, unwarranted medicalisation of emotional difficulties can engender unhelpful dependency. However, perhaps most disturbing for the practitioner is the experience of prescribing something without really understanding why, or what it is doing.

In fact, medicine is very familiar with treatments that seem to work for reasons that aren't understood. Historically, they have been known as placebo treatments. For centuries and throughout contemporary medical practice it is widely acknowledged that the authoritative offer of a credible treatment by someone acting in a well-meaning way can have a helpful effect irrespective of whether or not the intervention involves something known or believed by the practitioner to be relevant to the condition in question. In numerous medical conditions much can be achieved in ways that aren't fully understood, and the

term 'placebo effect' is usually used to account for it. In recent times, 'placebo' has become something of a dirty word, but this is unfortunate, misleading and distracts from serious consideration of what it might represent and how that might be used for the good.

Medicines are not just Chemicals: The Placebo Effect

As introduced a few lines earlier, one of the canons of medicine is that the way in which a treatment is presented has a strong effect upon its outcome. If it is presented authoritatively by someone who is clearly concerned to help and in a way that communicates confidence in its effectiveness, then it is more likely to work than after a presentation by someone who has come across as off-hand, tentative and uncertain. For centuries, doctors and their clientele have acknowledged that much can be achieved by presentation, the instillation of confidence and convincing evidence of support and concern.[12]

In the modern scientific era the placebo effect has acquired something of a sad reputation and, as a result, it is relatively under-researched, misunderstood and generally oversimplified. Psychopharmacology makes a lot more sense if some of these misunderstandings and oversimplifications are questioned. They include the dismissive judgement that if a condition responds to a placebo treatment, then the condition isn't 'real', that placebo treatments are inert and have no detectable biological effects, that the 'placebo effect' is a simple, predictable phenomenon, and that it has no useful part to play in explaining active treatments' effects. In fact, all of these are misleading generalisations.

To a large extent the placebo effect suffers a poor reputation because the modern era has relegated it to the role of the control condition in clinical trials. Legislation governing the use of medicines in practically all jurisdictions requires evidence of safety and efficacy before a new product can be made available and marketed, and this is usually obtained in the form of a clinical trial. A standard placebo-controlled randomised clinical trial is an arrangement whereby willing patients fulfilling predetermined diagnostic criteria and seeking help are allocated at random to treatment with the new drug or to treatment with a placebo. Under these circumstances 'placebo' means a pill or an injection that look just

[12] The use of 'placebo' is as old as medicine itself. A recent study of particular interest that teases out components of the 'placebo' response is one by Kaptchuk et al. (2008), who investigated the differential effects of various components of intervention with patients suffering irritable bowel syndrome.

like the medication or active agent undergoing trial, but don't contain anything with the same chemical properties. Treatment proceeds. Measures of symptom severity or other indicators of treatment success are made as this happens and at the end of a predetermined period statistical tests are used to determine whether or not, on average, those who have been taking the new drug or active agent have benefitted more than those taking the placebo. If there is a statistically significant difference in severity or symptom score between the active agent group and the placebo group at this end point it is attributed to the active agent. If it is advantageous the new drug can be considered effective and a candidate for approval by regulating authorities and marketing. What is of interest is what has happened to those taking the active agent that did not happen to those taking the placebo. What happens to the placebo group and what happens overall are relatively uninteresting as far as new product development is concerned, and tend to be overlooked. Figure 4.1 offers a simple illustration of such a trial.

Trials following this basic structure determine the fate of all new medicines, and that includes psychopharmaceuticals. Much of what has been written about how commercial pressures might influence the presentation of psychopharmaceutical drug trials' findings to potential prescribers and the public has already been referred to (see, e.g., Healy, 2002; Medawar and Hardon, 2004; Kirsch, 2009; Moncrieff, 2009, 2013).

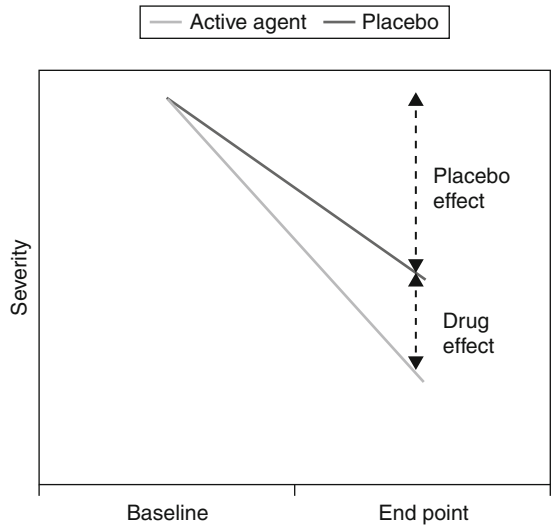

Figure 4.1 Drug and placebo effects in a typical clinical trial

This is not the place to review that.[13] However, this *is* the place to consider what is revealed by more careful consideration of what those findings are, what they reveal about the 'placebo effect' and how this can help clarify one of psychiatry's core conundrums.

A first observation is that those receiving placebo treatment don't stand still. In fact, a considerable proportion of them improve. This is what would be expected from a general understanding of placebo effects and it is what happens in real clinical trials, in particular those involving psychopharmaceuticals. A general finding is that the recovery rate amongst psychopharmaceutical drug trial patients given placebo is around 30%. Amongst those given an active agent it is around 50%.[14] In other words, more than half of the overall improvement experienced by those given an active agent in such trials could be due to something other than its chemical properties. Relegating the part played by 'placebo' in such trials to the role of comparator against which active agents are assessed draws attention away from the fact that so-called placebos can be very effective treatments in their own right. This does not sit easily alongside narrowly scientific approaches to psychiatry or even medical practice more widely, but it is an undeniable fact that has been accepted for a long time, and one that cannot be ignored.

A reason why modern medicine has such difficulty with placebo effects is that they challenge conventional distinctions between effects attributable to 'mind' and those attributable to 'body'; effects that are accessible to empirical scientific investigation. The restrictive consequences of this distinction hamper an understanding of psychiatry as a whole and psychopharmacology in particular. This is considered in more detail in Chapter 7 but the specific implications of it for an understanding of psychopharmacology are illustrated by two landmark

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[13] This discussion is taken up in Chapter 8.

[14] These are figures quoted in a review published by The British Association for Psychopharmacology, which formed the basis of later National Institute for Health and Clinical Care Excellence guidelines for the treatment and management of depression (Anderson et al., 2008). A more focused meta-analysis of placebo effects in antidepressant trials, which considered data from 9,566 patients participating in 96 trials, computed an overall within-group effect size (Cohen's *d*) of 1.69 for placebo patient groups and 2.5 for the active agent groups. On this basis, 67.6% of the improvement found in active antidepressant drug treatment groups can also be found in the placebo groups; only 37.4% of the improvement seen in active treatment groups can be attributed to the difference between them and placebo (Rief et al., 2009). Similar findings have been reported by a number of other investigators (Joffe et al., 1996; Walsh et al., 2002; Kirsch et al., 2008; Fournier et al., 2010). Significantly, one report is of no difference in suicide rates between placebo and active drug treatment groups (Khan et al., 2000).

experiments that have explored the placebo effect. Pain is susceptible to many forms of treatment and it lends itself well to placebo research. These experiments both concern manipulations of pain in ways that explore the effects of placebo treatment upon it.

The first of is the so-called naloxone experiment.[15] This concerns the effects of placebo upon the experience of pain. The experience of pain is generally understood to involve the activity of endogenous opiates,[16] which can be interfered with by opiate-blocking drugs such as naloxone, and it is well established that giving naloxone at the same time interferes with the pain-relieving effect of morphine. It is also well established that many forms of pain can be alleviated by an injection of saline solution when the subject believes it to be an injection of morphine. In essence, what the experiment demonstrates is that naloxone interferes with the pain-relieving effect of a saline injection that patients believe to be a morphine injection, but not when they know it isn't. An interpretation has to be that however the pain-relieving effect of a saline injection believed to be morphine is mediated, it must include the activity of endogenous opiates, which can be interfered with at a chemical level by naloxone.

The second concerns the effects of a treatment's appearance. The colour, size and other aspects of a pill can all influence its effects independently of its chemical contents. In a classic experiment that explored this, the effect of a brand name was investigated.[17] It concerned the headache-relieving effects of tablets believed to contain aspirin. As predicted, inert tablets believed to contain aspirin were effective. The strength of that effect was sensitive to whether or not the tablets were labelled as if they were an aspirin preparation widely promoted at the time. Furthermore, this 'branding' effect was stronger amongst patients already in the habit of using that brand of aspirin for the treatment of headaches. Unsurprisingly, branding also influenced the headache-relieving effect of aspirin-containing pills. These are generally acknowledged findings, and many similar experiments have shown that the appearance of a pill can influence its effects independently of their chemical composition, sometimes in ways that are clearly peculiar to the individual's taste.[18]

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[15] Originally attributed to Levine et al. (1978). Subsequently reproduced by several other groups whose work has been reviewed by Riet et al. (1998).

[16] Endogenous: arising in the body, in this case the brain and part of naturally occurring processes.

[17] Originally reported by Branthwaite and Cooper (1981).

[18] Blue is reported to make pills more calming than other colours, apart, apparently, from in Italian men for whom it is the colour of the nation's football team (Moerman, 2002).

These illustrative experiments and the much larger placebo effect literature speak to psychopharmacology in important ways. The naloxone experiment demonstrates that it is unhelpful to insist upon a clear distinction between chemical and psychological determinants of a treatment's success, or enter a debate about what is and what is not 'real'. Given the inherent complexities of brain chemistry outlined above and the irreducible fact that however conceived, psychological processes are an expression of it, this is unsurprising, even though it challenges conventional distinctions between what is 'psychological' and what is 'physical'. The naloxone experiment is hard to interpret without accepting that a psychological influence can have an identifiable chemical effect. The branding experiment illustrates the many ways in which psychological influences can have such an effect. Together they demonstrate something that is important but often overlooked concerning medical treatments. It is that the sources of their effects are not limited to their chemical properties and that sources of effect that lie beyond their chemical properties are complex and have to be understood from a variety of perspectives. This has implications for how the so-called 'placebo effect' should be understood, and it offers insight into what is happening when someone is offered, accepts and takes a psychopharmaceutical remedy.

Sadly, the term 'placebo' has become so stigmatised that to suggest psychopharmaceuticals might be acting in such a way is unpopular and deemed by many who might take them to be disrespectful of the reality of their difficulties. The term 'placebo' tends to be used in a derogatory way and in reference to influences upon treatment outcome that are ill defined, messy, difficult to understand and interfere with 'proper', intended and scientifically defined treatments. In fact, the 'placebo effect' is a very real phenomenon and it is closely allied to other theoretical and experimental developments in consciousness and decision-making research.[19] A difficulty with the term 'placebo' is that it has come to be used as a blanket expression explicitly lumping together everything that might influence the outcome of a medical treatment apart from

[19] Principally Antonio Damasio (1996) but other investigators, too, have developed the somatic marker hypothesis. This draws attention to the role of feelings derived from interpretations of bodily or somatic sensations in decision making. In essence, it is scientific validation of the folklore concerning gut (and other) feelings when a situation has to be evaluated. It provides a highly credible way of understanding how drugs such as psychopharmaceuticals, which commonly do have significant effects upon heart rate, physiological adjustments to posture and exercise, intestinal motility, arousal and bowel movements, might exert psychological effects independently of any direct chemical effect they might have upon brain pathways.

its chemically understood effects. The naloxone experiment demonstrates that placebo effects can include chemically relevant effects and the branding experiment illustrates how misleading it is to restrict an understanding of this phenomenon to a lumping together of everything other than a drug's chemical properties. The so-called placebo effect reflects the actions of a potentially wide range of influences upon treatment outcome, which are very real to all concerned, whether arbitrarily construed as psychological or not.[20] Importantly, these include how the offer of treatment is made, and how that is experienced and understood.

Experiencing Psychiatric Drug Treatment

Psychopharmaceuticals are used in a wide range of contexts that convey a wide range of meanings. They may be prescribed by a doctor in the course of a consultation by someone seeking professional help with their troubles. They may be administered in a difficult situation where there is consensus that someone has to be medicated for the common good, even if the troubled person is not acknowledging that need at the time. Where they can be bought across the counter they may be purchased by someone who has their own reasons to believe the medicine in question will be helpful. Each of these contexts and the infinite number of other theoretically possible permutations introduces its own meaning and implications into the overall business of being prescribed, obtaining and taking a medication. Furthermore, psychopharmaceuticals have discernible effects. These may be considered side effects or they may be considered intended effects, but whichever that may be psychopharmaceuticals' chemical properties result in effects the recipient will experience and interpret in their own way. The result is a personally meaningful experience of taking medication, which embraces far more than just its chemically identifiable effects.[21] It may be welcome, it may be unwelcome, but it is real.

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[20] Andrew Turner goes into this in more detail, in the form of an unpublished PhD thesis (2011) and a related publication (2012). He argues that it is not possible to separate a placebo treatment from the context in which it is being applied, and that this differs from situation to situation. Thus, there is no such thing as a generic 'placebo', rather, when used as a control in clinical trials alternatives to the active treatment, are comparable with the control of compounding variables in other forms of experimentation. This draws attention to the active effects of the many variables that can influence a therapeutic interaction, that they are inappropriately lumped together under the term 'placebo effect' and are better considered separately as different foci of analysis.

[21] Joanna Moncrieff has to be credited with a first articulation of this view, but more robust incorporation of what can be learned from placebo studies strengthens it (Moncrieff and Cohen, 2005).

Amongst the commonly used psychopharmaceuticals, benzodiazepines and antipsychotic agents are explicitly and undeniably sedating. The subjective experience of sedation differs between them. On the whole, benzodiazepines induce a state of pleasant tranquillity with few troubling short-term side effects other than drowsiness, which might be welcome if sedation is the reason for taking the medicine in the first place. Antipsychotic agents induce a state of psychic numbing, which many report as unwelcome, as an experience of not being in touch with the world or being able to gather thoughts. Taking an antipsychotic is also commonly associated with sexual impotence in men, and with a sense of muscular tension and uncertainty.[22] They do, however, often give some relief from troubling mental experiences, which might be welcome to some in certain situations. Circumstances in which sedation might be considered desirable could include a situation in which all concerned, including the disturbed person agree that it is necessary, one in which the disturbed person is a cause of concern to others but does not share those concerns and is to be sedated against their wishes in order to alleviate others' concerns, and a situation in which someone is seeking immediate relief from discomfort or distress, possibly at the expense of not working it through in a more enduring way. In caricature these various uses of sedation range from a chemical cosh, in the case of the disturbing but unwilling recipient, to the drowning of sorrows in the case of someone seeking relief from their distress. The direct effects of the drug will have some influence upon how the treatment is experienced, but meaning and context will also play their parts in determining how it is appreciated. In particular, they will influence whether or not the patient experiences the medicine as a helpful treatment or a form of constraint. The former is unlikely if it is a drug with adverse side effects and it has been imposed upon them, quite likely if the subjective experiences are welcomed and it has been provided in response to a mutually acknowledged understanding of difficulties, and a possible source of concern over dependency amongst others if it has been taken as a way of avoiding necessary but uncomfortable change and development. Given lessons from the study of placebos, where these aspects of how a medical treatment is experienced emerge as undeniably important determinants of outcome, it is not difficult to see wide scope for an understanding of how psychopharmaceuticals might have quite profound effects that are only partly explained by their direct chemical properties.

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[22] See Jim Read's *Psychiatric Drugs* (2009).

To Summarise

Science itself has difficulties with psychopharmacology. It is clear that it is not possible to attribute any one identifiable mental health difficulty to the dysfunction of any one identifiable element of brain chemistry that can reasonably be targeted by a drug treatment. Psychopharmacology is not a set of safe and harmless interventions that 'won't do any harm and might do some good'. All psychopharmaceuticals induce changes in brain chemistry that are only partially understood, and some of these may result in withdrawal effects or even iatrogenic dependency.[23] There are concerning increases in the use of psychopharmaceuticals for unclear reasons. In large part, this reflects voluminous clinical trial data, prescribers' experiences and many users' testimonies. This is a worrying state of affairs.

The actions of psychopharmaceuticals can be much better understood through reference to what is known about placebo effects in other areas of medical practice. From this work it is clear that taking medicine is a much more complex business than just submitting to the chemical effects. Taking a medicine is a process with meaning that can be desired or undesired, experienced as pleasant or unpleasant, and as imposed or readily embraced. Studies of the placebo effect make it perfectly clear that these dimensions of medicine-taking can have a profound effect upon its effects. Psychopharmacology has acquired a major role in contemporary psychiatric practice for reasons that are presented scientifically but are not scientifically founded. That role has given it a credibility that influences how psychiatric medicines are experienced by those who take them and the practices of those who prescribe them. These are real effects that influence how people respond to them but it has to be acknowledged as misleading to attribute all helpful effects to their chemical properties. Doing so can distract from understanding these processes more accurately and from seeking alternative and less harmful ways of providing for those in need. In relation to this, it is also important to consider the part that might have been played by so-called placebo effects in clinical trials that have generated psychopharmaceuticals' reputation for effectiveness.

As already noted, all psychopharmaceuticals have subjectively discernible effects such as sedation, nausea or a dry mouth. As a result, in any psychopharmaceutical drug trial there are important differences

[23] Iatrogenic, caused by medical intervention.

between groups that are not usually taken into account. Those running randomised, placebo-controlled clinical trials go to considerable lengths to prevent patients and those administering to them from directly knowing whether they are taking the placebo or active agent. Pills are made to appear indistinguishable. Routines of prescription and pill taking are carefully matched, and those responsible for patients' clinical care and assessments are kept in the dark about which group any one patients might belong to. Unfortunately, these precautions only very rarely extend to patients' subjective experiences. Many of those taking the active agent know they are taking it, and many of those taking the placebo know that they are not.[24] Thus, there is scope for differences in the strength of placebo effect between groups. Those suspecting that they are taking the active agent can experience themselves as being provided with a credible and possibly effective treatment. Those suspecting that they are taking the placebo may justifiably experience themselves as deprived of treatment. Given the importance of credibility and a sense of being authoritatively treated in determining the placebo effect, it is perfectly possible that those knowing they are taking the active agent will enjoy a stronger placebo effect than those who have accurately guessed they aren't. This is a serious methodological flaw that is not generally acknowledged. If and when it is it throws considerable doubt upon the validity of conclusions drawn from the vast majority of clinical trials that claim that psycho-pharmaceuticals' benefits, when they occur, are exclusively due to their chemical properties.[25] More is made of this, and of the more general implications of an approach to psychopharmacology that incorporates what can be learned from 'placebo' effects, in Chapter 8.

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[24] This has been explicitly documented (Rabkin et al., 1986; Fisher and Greenberg, 1993).

[25] Clearly, a way round this difficulty would be to use a comparison treatment that mimicked prominent side effects but that lacks any of the presumed therapeutic properties. This was done in a small number of trials investigating earlier antidepressants, which, notably, caused a dry mouth, urinary difficulties and other so-called anticholinergic side effects. These can be mimicked by atropine. A review identified only nine such trials (Moncrieff et al., 1998). Methodological differences between them made formal meta-analysis difficult to interpret, but only two of the nine studies reported a consistent effect in favour of the active drug. Clinical trials supporting claims of efficacy amongst later antidepressants have not been able to even attempt this more refined approach to controlling for the unblinding effects of subjective experiences because an appropriate way of mimicking them has not been found.

5
‘Psychotherapy’

For many the experience of going to a psychiatrist will be one that concludes with ‘Do you want treatment with medication or do you want psychotherapy?’ It may appear odd that these are presented as clear alternatives, considering how different they are. If there were clear reasons for identifying medical treatment as best for certain mental health difficulties and psychotherapy as best for others, then it would be reasonable to expect a psychiatrist to be able to be clear which might be most helpful in any one case. As it is, formal recommendations concerning the treatment of most forms of mental health difficulties refer in differing ways to both medical and psychotherapeutic interventions.[1] Chapters 3 and 4 clarify why it is that psychiatric drug treatments are not and cannot be as precisely targeted and applied as might be expected, and why it is that what comes to be prescribed is as much determined by the detailed specifics of the individual and the difficulties they are in, as it is by ‘diagnosis’ or the scientific underpinnings of psychopharmacology. Much the same is true for psychological therapies. Some have reputations for greater efficacy in certain situations but all are claimed, by some, to be effective in all conditions, and all prove ineffective in some people, regardless of the situation. This chapter provides an outline of the psychotherapies as they are presented

[1] National Institute for Health and Care Excellence guidelines concerning the management and treatment of anxiety disorder, depression, bipolar disorder, psychosis and schizophrenia, personality disorders, eating disorders, chronic fatigue syndrome, alcohol use disorders and attention deficit hyperactivity disorder (https://www.nice.org.uk/guidancemenu/conditions-and-diseases#/guidancemenu/conditions-and-diseases/mental-health-and-behavioural-conditions; accessed October 2014).

in standard textbooks and in conventional psychiatric settings. It then goes on to explore what they might actually be, and why rather odd conclusions such as this might be, after all, unsurprising.

There are numerous terms that refer to 'psychotherapy'. They include counselling, cognitive behaviour therapy (CBT), psychoanalysis, psychodynamic psychotherapy, group therapy and more. This may be confusing to the uninitiated but it is inescapable. 'Psychotherapy' also overlaps with wise counsel, training, coaching, religious teaching and the many other forms of support and advice that crop up in everyday life, and so it is unsurprising that it takes many forms. People are hard wired to reach out to the confused and their distressed brethren,[2] and 'psychotherapy' can reasonably be seen as nothing less than an organised and professional way of doing this. Two or more people meet and interact with the aim of relieving emotional, behavioural and/or psychological difficulties. The form this might take will reflect the nature of the difficulties, the context within which it is happening and the inclinations therapist and client each bring to the table. What actually happens will depend upon how all these fit together, and so it is understandable that, in practice, there are many permutations.

The therapist's inclinations will reflect their own interests in pursuing their profession, their training and experience and their institutional setting. They are likely to be doing this for a living and will be either self-employed or employed by a healthcare organisation. If the therapist is self-employed, then clients have to be willing and able to pay. If the therapist is an employee, then the employing organisation will determine what the therapist does or does not offer, to whom and for what sorts of difficulties. This can limit what is available. From the client's point of view nothing will be achieved unless they can connect with that. What is available has to be seen as appropriate and realistic. Therapy is an intimate and intimidating undertaking. It lays emphasis upon disclosures and admissions of vulnerability. Clients are unlikely to engage with this unless it feels safe. The therapist has to come across as someone with the right balance of professional authority and approachability, and people differ widely in what that means to them. Is the psychotherapy on offer one that comes with positive reports from my reading or recommendations from others I trust? Is my understanding of my difficulties reflected in what I understand the therapist's to be? Do the setting and other practicalities promise safety and reassurance?

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[2] See the discussion concerning empathy and emotional interactions in Chapter 7.

Nothing psychotherapeutically helpful will happen unless there is a true meeting of minds. Whether or not that happens will depend upon how well the therapist can interpret the problems that are to be addressed in ways that make sense to the client, provide a convincing rationale for their meetings and is able to conduct them in a suitable way.

This the real background to the multitude of psychotherapies. Different problems are understood in different ways by different people. Money, waiting lists, terms of employment and institutional commissioning arrangements all influence what might be available to any one person in a particular time and place. Whether or not a helpful meeting of minds can happen depends upon how well all of these match up. That is not to say that anything goes. For a therapist to be viewed as a respected professional they must show evidence of training and expertise, and these, in turn, have to be based upon theory and knowledge. As a result, therapists present themselves as trained and preferring to work in a particular way: a 'gestalt therapist', a 'psychoanalyst', a 'cognitive behaviour therapist', and so on. These genres reflect differing theoretical frameworks, approaches to how therapy might be conducted in practice and the sorts of problem it might be considered best suited for. They reflect the training opportunities and qualifications available to aspiring therapists. They inform commissioning debates within healthcare organisations, and they offer the curious client some idea of what to expect. Leading textbooks cut the cake in slightly different ways.[3] This account outlines the different schools of psychotherapy in terms of psychoanalytic and psychodynamic approaches, behavioural and cognitive approaches, and humanistic–existential and transpersonal approaches. In reality, there are considerable overlaps, and current opinion is that what the different psychotherapies have in common is far more important than their differences. Nevertheless, these groupings do reflect historically

[3] Roth and Fonaghy reviewed the research relating different forms of therapy to differing groups of psychiatric disorder, and differentiated between psychodynamic therapy, behavioural and cognitive behavioural therapies, interpersonal psychotherapy, systemic orientations, supportive and experiential therapies, group therapies and counselling (2006, pp. 5–13). There are ideological overlaps between these, in particular between interpersonal psychotherapy, systemic orientations and group therapies, and between supportive and experiential therapies, and counselling. *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change* (Lambert, 2013) distinguishes between behaviour therapy, cognitive and cognitive behavioural therapies, dynamic therapies and humanistic psychotherapies.

distinct developments, differing schools of psychological theory and separate intellectual traditions.

Psychoanalytic and Psychodynamic Approaches

These are the approaches that have their origins in the practices and theorising of Sigmund Freud. Freud played a critical part in the development of psychiatric thought, if not Western thought and philosophy more widely. Put most simply, he proposed and illustrated how apparently incomprehensible actions and experiences could be understood and have meaning if set in a framework that acknowledges unconscious influences upon them. In Western circles it is now widely accepted that all of our choices, actions and experiences are influenced, in part, by unconscious processes. That was not a widely held perspective before the turn of the twentieth century, when Freud's work began to acquire influence. It certainly played very little part in how 'madness' or other forms of mental health difficulty were understood. Freud offered an explanation of how the longer-term consequences of childhood experience, and immediate difficulties, challenges and relationships can interact to result in otherwise incomprehensible behaviours and feelings. He provided a model for these interactions in terms of ways in which unconscious 'forces' might be expressed in everyday life, and prescribed a technique that offers a route into understanding them. For a number of reasons, which include cost (Freudian psychoanalysis is generally quite prolonged), reluctance to subject the theory and derived practices to scientific investigation, and, as a result, only limited scientific evidence for efficacy, psychoanalytic and psychodynamic therapies are no longer widely available through institutional healthcare providers in either the USA or the UK. They continue to enjoy popularity amongst the more privileged fee-paying constituency. Here the distinction between a cost-effective evidence-based 'treatment' and improving self-knowledge is less pressing. Nevertheless, Freud's legacy is considerable, and it is fair to say the entire psychotherapeutic enterprise has been formatively influenced by it.

Psychoanalytic theory and practice derived from observations that problematic behaviour could resolve if the afflicted was able to articulate and acknowledge otherwise unacceptable truths. An example might be the development of paralysis in a young woman who has found herself obliged to care for ageing parents. The unacceptable truth, the inadmissible conflict, is that she experiences the commitment to caring for her parents as an obstacle to falling in love, marrying and having a

family of her own. Openly saying so and even acknowledging this to herself might be impossible. It would put both her and her parents in a difficult position where the choice between her caring for them or getting on with her own life has to be addressed, with all the uncomfortable associated implications. A large part of her does not want to care for them but she finds it impossible not to … a classic 'no-win' situation. The development of 'hysterical' or functional paralysis that interferes with her ability to keep on top of housework is a way of getting out of it, even though it might also interfere with her chances of finding a husband.[4] Bizarre though it might be for an otherwise fit young woman to lose the use of her right arm for no discernible neurological reason, given the context in which it has happened it does make a form of sense. A psychoanalytic approach to this difficulty would enable her to articulate her conflict in the safe environment of the consulting room, and begin a more realistic way of addressing her dilemma.

Freud developed his theory of human personality on the basis of observations such as this. He conceived of it as an interplay between three sets of forces; id, ego and superego. Id is understood to refer to those parts of the personality people are born with and which comprise basic biological urges towards sex, food, warmth or elimination, which are deemed unconscious and essential. Ego refers to those forces that engage with and are influenced by the reality of the external world, and superego refers to social and moral standards that reflect how one feels one *should* behave. Ego and superego are, in part, consciously experienced. Thus, in the case of the illustrative young woman, her interest in love and marriage could be construed as expressions of id. Conflicting with this is a keenly felt obligation to care for her ageing parents particularly keenly. Not everyone would even consider committing to this without question, and her readiness to do so could be construed as a reflection of how her superego has configured and reads this situation. It is, for instance, possible that her own mother sacrificed a lot to care for elderly parents and our young woman grew up in an atmosphere that regarded this as normal, as how one *should* behave. Unlike her mother, her situation is that she is faced with doing this before finding

[4] Hysterical paralysis is the term used to refer to paralysis, often of a limb or of the ability to carry out certain simple tasks such as walking or reaching, which cannot be explained in terms of identifiable physical abnormalities of the nervous system. 'Hysterical' or 'functional' disabilities can also include difficulties speaking, seeing or hearing: elective mutism, hysterical blindness or hysterical deafness respectively.

a husband and building her own home. Inherent forces (id), values and expectations (superego), and practicalities are in conflict. The result is a psychological defence, a way out of the conflict that avoids the immediate discomfort of addressing it, but at the expense of honesty and in a way that is likely to lead to other difficulties.

Psychoanalytic thinking has developed the concept of defence mechanisms in ways that provide explanations for a wide range, if not of all apparently irrational behaviours and experiences. Some examples are given below.[5]

1. *Denial*
   Refusing to face reality, behaving in a way that suggests the person is unaware of something he or she might be expected to know, for example refusing to accept that smoking is related to cancer or the early stages of a bereavement, when the pain of loss is too intense to bear.
2. *Repression*
   Prevention of painful, unacceptable, and dangerous thoughts and emotions from entering consciousness, for example a person who has been assaulted cannot remember what happened, or a man fails to recognise an attraction to his daughter-in-law, but still behaves lewdly towards her.
3. *Projection*
   Attributing one's own unacceptable negative thoughts and feelings to another, for example an employee who is angry at his boss because he is convinced that his boss is angry with him, or a teacher who is attracted to her student believes that the student is attracted to her.
4. *Reaction formation*
   Preventing the awareness of unacceptable desires by the adoption of the opposite behaviour, for example, acting towards a sexually attractive person in a cold and hostile manner, or reacting to homosexual attractions by expressing strong homophobic attitudes.
5. *Displacement*
   Venting feelings on less dangerous, substitute people or objects, for example feeling angry with a colleague at work and then coming home to shout at the children, or smashing a plate during a marital argument rather than becoming violent.
6. *Intellectualisation*
   Cutting off from emotional awareness, for example talking about a life-threatening situation in a cold, calm and analytic way.

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[5] With acknowledgments to Stephen Joseph (2010, p. 54).

7. *Regression*
   Reverting to an earlier developmental level in which behaviour is less mature, for example sulking like a child during an argument, or having a temper tantrum when things do not go the way that was hoped for.
8. *Identification*
   Affiliating oneself with a group or another person often perceived to be of high standing, for example an insecure young man emulating a movie idol or a rock star known for a particular style of dress or set of mannerisms.
9. *Sublimation*
   Channeling frustrated energy into socially acceptable activities, for example dealing with conflict and aggression by taking up boxing or martial arts.
10. *Rationalisation*
    Making socially acceptable explanations that are based on unacceptable motives in order to justify behaviour or to conceal disappointment, for example after being sexually rejected deciding that the other person was unattractive, or after failing to be offered a job deciding that it wasn't suitable.

It is clear from these descriptions that construing ordinary behaviours in these ways offers an explanation for much of everyday life, as indeed Freud did (see Freud, 1901). However, seriously troublesome and distressing behaviours that become the business of mental health professionals can also be understood from this perspective. On the basis of their severity, persistence and untoward consequences, Vaillant (1992) classifies defence mechanisms as 'Pathological', 'Immature', 'Neurotic' or 'Mature'. The young spinster's hysterical paralysis would be an example of a pathological degree of sublimation. Another might be intense denial, a blunt refusal to accept external reality because it is too threatening or anxiety provoking. Someone behaving like this is going to be difficult to live alongside and, given their reluctance to share the same interpretation of events as others, might well be considered psychotic. Immature forms of psychological defence include acting out, forms of regression where relatively unmodified urges find inappropriate expression as in moody withdrawal or unsolicited sexual advances, or the indirect, passive expression of aggression. Neurotic forms of psychological defence include dissociation, in which there is a temporary disconnection from immediate reality in order to avoid emotional distress. A mundane example of this is the slowing down and sense of the unreal that many report during the moments leading up to a road accident. The full implications of what

is about to happen are switched off. This protects consciousness and the ability to take last-second avoidant actions from the disruption full realisation of impending injury would bring. Otherwise unexplained dissociation is often experienced as a strange and disturbing state of mind, and someone who is not fully engaged with the world is a source of difficulty to others. Mature defences include the ploys and strategies used to manage tensions between what might be considered desirable and what is realistic, such as patience, a productive form of sublimation, courage, an adaptive form of denial or humour, a helpful form of displacement.

The business of enabling someone to understand themselves in these terms is a classic psychoanalysis. It is an intense process usually conducted as several sessions per week over a period of several years. During them the client will be encouraged to freely associate, to say whatever comes into their mind, however trivial. This might include the remembered content of dreams. The analyst attends to the stream of consciousness for evidence of irregularities and inconsistencies that can be interpreted as defences against the psychic discomfort threatened by tussles between unfulfilled primitive urges for comfort, safety, nourishment and sexual gratification (id), idealised expectations of what *should* be (superego) and the perceived constraints of here and now (ego). This offers the client insight into the nature and origins of unwanted or troublesome behaviours and feelings. Classic psychoanalysis is conducted with particular attention to setting and boundaries with the aim of developing a narrowly specific context of time, place and ritual, which provide the intimacy and containment necessary for the process to proceed. Commonly, clients experience this intimacy in one form or another of recognisable relationship: child/parent, rivalry, authoritarian/submissive or romantic/erotic. These experiences are referred to as transference, the transfer or spread of unconscious relational propensities into the hothouse of the therapeutic setting. By recognising the development of transference and the form it is taking the therapist can also make interpretations of how it reflects workings of the client's unconscious. Classic Freudian psychoanalysis can also be experienced as a very rigid orthodoxy. The format and frequency of sessions are firmly prescribed. Qualifying therapists have to have undergone prolonged analysis in their own right, and Freud's theoretical framework is applied unquestioningly. As a result, classic Freudian psychoanalytic practice is limited to a relatively small body of practitioners. A much greater number of psychodynamic psychotherapists offer therapy that

draws heavily upon Freud and attends to identifying psychological defences and interpreting transference, but does so in ways that are less rigidly orthodox. Early deviations from Freudian orthodoxy were led by Carl Jung and by Alfred Adler. Both were close friends and associates of Freud, and both publicly disagreed with him.[6] Both were frustrated by the rigidity of his theorising, in particular with his focus upon infantile sexuality and the sexual nature of primitive drives, but they also shared different interests in recognising and exploring how personal growth and development continue in adult life. Psychoanalytic and psychodynamic approaches now embrace these and other stands of theory and practice but their common underpinning framework continues to be a search for and interpretation of internal psychological conflict.

Two explicit criticisms of psychoanalysis are that it is beyond the reach of science and that it is patronising. It is pejorative to identify unhelpful forms of psychological defence as 'immature' and helpful forms as 'mature'. From a psychoanalytic perspective the troubled person is viewed as immature and underdeveloped. Difficulties are construed as the result of imperfect psychological development and viewed as defects to be corrected. There may be some wider validity in this. Emotionally unsatisfactory childhood experiences undoubtedly contribute to mental health difficulties in adolescence and adult life,[7] and it is now generally accepted that an emotionally sound childhood is an important prerequisite for psychological well-being in adulthood. Many of Freud's intellectual successors have contributed to this.[8] Nevertheless, the notion psychoanalysis promotes, that mental health difficulties can be understood as the result of imperfect psychological development, does influence how it is viewed. It contributes to perceptions of psychoanalysis as a self-indulgent pursuit of the privileged (see Moscovici, 2008, pp. 201–14), or techniques that might be useful for the ambitious who want to develop interpersonal skills, enhance self-understanding and overcome self-defeating behaviour in order to be more effective

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[6] Carl Jung (1875–1961) was the first president of the International Psychoanalytic Society, who resigned around 1914 because he had no wish to be viewed as Freud's heir. Alfred Adler (1870–1937) was an early collaborator with Freud. He was president of the Vienna Psychoanalytic Society and when he resigned membership was divided between his and Freud's followers.

[7] In one large and epidemiologically sound study emotionally adverse childhood experiences were estimated to have contributed nearly one-third the risk of developing a Diagnostic and Statistical Manual of Mental Disorders-defined mental illness in later life (Green et al., 2010).

[8] The list includes Melanie Klein, John Bowlby, Mary Ainsworth and Erik Erikson.

(see Roberts and Brunning, 2008), rather than a therapy to assist the afflicted. Perhaps this is unfortunate. However, this is not the main reason psychoanalysis has fallen out of favour with healthcare-funding organisations. That has happened because psychoanalytic theory is closer in kind to an all-embracing world view than it is to a testable scientific hypothesis. In general, psychoanalytic and psychodynamic therapies are prolonged and therefore expensive. Located as they are amongst ill-defined phenomena such as personal insight, meaning and maturity, outcomes are difficult to measure. As a result, it has been difficult for proponents to justify these costs on the basis of evidence drawn from clinical trials and other conventional ways of assessing cost-effectiveness that are the currency of healthcare-commissioning organisations.

As a result, the contributions psychoanalytic and psychodynamic approaches make to public mental health services are more indirect and subliminal than they are overt and explicit. Their origins and background are the bases of general acceptance that in some way and by various means unconscious forces play an important part in determining feelings and behaviour. By laying emphasis upon this they provide a rationale for seeking the individualised meaning of even the most bizarre and apparently incomprehensible actions. They have directed attention to the influences of emotional experiences during childhood and adolescence upon adult psychological well-being. Most conventional public mental health services employ few, if any, practitioners who exclusively offer psychoanalytic or psychodynamic therapies, but most therapists employed by most such organisations will have been profoundly influenced by what can be learned from them. Furthermore, Freudian psychoanalysis has played a large part in forming popular perceptions of psychotherapy, and therefore what potential clients might expect from them.

Behavioural and Cognitive Approaches

Behavioural therapy and CBT have their origins in a reaction to the unscientific nature of psychoanalytic approaches and the lack of reliable evidence for their efficacy. In the UK this was led by Hans Eysenck during the 1950s and 1960s.[9] Rather than theorising in

[9] Hans Eysenck (1916–97) was Professor of Psychology at the Institute of Psychiatry in London from 1955 until 1983. He was a committed proponent of the application of scientific methods to the evaluation of psychotherapies, and in a paper published in 1952 famously concluded that available data 'fail to support the hypothesis that psychotherapy facilitates recovery from neurotic disorder' (Eysenck, 1952, p. 323).

armchair fashion about observations made in the clinic as Freud had done, Eysenck and his followers set out to apply what they could from scientifically derived knowledge acquired in the laboratories of experimental psychologists. Classical or Pavlovian conditioning had already been explored and applied to the study of human psychological difficulties.[10] In 1920, Watson and Rayner reported an experiment in which they had caused an 11-month-old boy, 'Little Albert', to become fearful of a white rat and other white and fluffy objects by making a startling loud noise whenever he reached out to stroke the rat.[11] Shortly afterwards, another study was published in which another small boy, 'Little Peter', who was already fearful of white rats and rabbits was enabled to overcome that fear by being supported through progressive familiarisation with them (Jones, 1924). The case had been made that scientifically credible approaches could be applied to the modification of human behaviour.

Experimental psychology also explored what has come to be known as operant or instrumental conditioning notably associated with the work of B.F. Skinner, who coined the term in 1953.[12] In the laboratory, operant conditioning refers to the shaping of suitable animals' behaviours by making food, water or other rewards (reinforcers) contingent upon them. The animal learns to execute a contingent behaviour such as pressing a lever or pecking a target in a reliable way. Many permutations have been investigated demonstrating that the contingent behaviour can be extinguished by withholding the reinforcer, the contingent behaviour can be elicited by a previously neutral or meaningless stimulus that has been associated with a primary reinforcer in

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[10] Russian psychologist Ivan Pavlov (1849–1936) demonstrated that dogs could be caused to salivate in response to a bell if the bell had previously been paired with something such as food, which would automatically stimulate salivation. By conditioning a previously meaningless stimulus (bell) by association with a meaningful (unconditioned) stimulus (food), the meaningless stimulus acquires similar salience (becomes a conditioned stimulus) and is able to evoke the same response.

[11] An experiment that might not win ethical approval nowadays but one that demonstrated that there were no *a priori* differences between what could be achieved in the animal behaviour laboratory and in humans (Watson and Rayner, 1920).

[12] B.F. Skinner (1904–90) was an American psychologist known for the Skinner box, an integral feature of his work, which focused upon how contingencies can shape behaviour, and an ardent proponent of the view that behavioural modification in response to contingencies is a sufficient explanation for human action and choices. The first use of the term operant conditioning is found in his 1953 work, which spells out these views (Skinner, 1953).

much the same way as Pavlovian conditioning, that certain drugs can act as reinforcers, often with quite dramatic effects, and that manipulations of the predictability of reinforcement following the contingent behaviour influence the strength of conditioning and how resistant or otherwise it is to extinction following withdrawal of the reinforcer. Classical, simple or Pavlovian conditioning, and operant or instrumental conditioning offer ways in which changes in behaviour can be studied scientifically and provide a scientific rationale for the therapeutic manipulation of circumstances and contingencies with a view to altering unwanted behaviour. A familiar example is the treatment of bedwetting. A moisture-sensitive pad in the bed sounds an alarm when the child wets it, and wakes the child. Before long the child associates the sensation of a full bladder with waking, wakes spontaneously when necessary and ceases to wet the bed. Other specific behavioural therapies that have been developed from this background include systematic desensitisation, flooding, aversion therapy and the use of token economies. Shortcomings have emerged with all of them, and apart from the use of systematic desensitisation in the treatment of certain phobias they no longer have a central place in most psychotherapeutic repertoires.

Systematic desensitisation or graded exposure is a wider application of the technique employed in the treatment of Little Peter's fears. The conditions it is most used for are the specific phobias such as spider and other insect phobias, height phobia, and specific fears of dogs and other animals. The therapist teaches the client how to relax, and provides reassurance when introducing the client to a mild degree of exposure to the feared object: a spider in a jar on the other side of the room or the bottom step of a ladder. Once the client has become comfortable with this relatively mild level of exposure progressively stronger exposures are introduced while ensuring that the client is comfortable with each before moving on to the next strongest. Increments might be spread over several sessions and homework might be organised in order to ensure gains are maintained. Step by step the spider-containing jar might be moved closer to the client. The spider might then be allowed to run around in a tray, and finally crawl on the client's arm. Critical ingredients are that the client is reassured by the therapist's lack of fear, that they have acquired the ability to relax and contain their anxiety at each step and that moving on to stronger exposure only happens when they are comfortable with the level they have already reached.

As its name suggests, flooding is full introduction of the feared object at the outset. Understandably, it causes extreme anxiety, and success is highly dependent upon the therapist's ability to reassure and contain the client's concerns. Graded exposure has proved to be more acceptable to more clients and flooding is now rarely used. Aversion therapy is an application of classical conditioning in which an unpleasant stimulus such as an electric shock or a medicine that causes nausea is associated with unwanted behaviour such as smoking or drinking alcohol. The unwanted behaviour becomes associated with the unpleasant experience and it extinguishes. Although this is theoretically sound from a behavioural science perspective its efficacy is limited and it does have ethical limitations, particularly when applied to the 'treatment' of sexual disorders and even homosexuality, as has been the case in the past. Token economies are modelled on a simplified view of real-world economies and the theoretical framework provided by operant conditioning; that behaviour can be modified by providing a reward (money in the real world, tokens in a token economy) in response to desired behaviour and withholding or even taking it away in response to undesired behaviour. Application of a token economy with therapeutic aims involves detailed analysis of the behaviours in question, their contingencies and the opportunity to engage with them in considerable detail. In general, this is only realistic in a residential setting, which narrows its applications. Furthermore, there are ethical constraints upon the extent to which it is considered acceptable to manipulate behaviour in this way.

Although behavioural therapies are based upon clear scientifically verifiable principles and avoid engagement with intangibles such as thoughts and feelings, strict avoidance of considering thoughts and feelings limits their application. Humans are far more complex than laboratory animals. A particular behaviour, such as striking out at another care home resident might reflect an entirely different set of perceived contingencies and feelings in one person than it does in another. The success of graded exposure is heavily dependent upon the success with which the therapist is able to develop a reassuring relationship with the client that enables them to contain the anxiety provoked by the feared object, perhaps a spider, without running from the room. As a result of these practical limitations and experimental findings scientifically minded therapists have had to acknowledge and embrace internal processes of thinking, reasoning and cognition into their theorising and practices. This takes account

of the fact that behaviour is not the direct result of environmental contingencies, as Skinner and other pure behaviourists would argue, but that it is the result of how those contingencies are understood and evaluated. This introduces an intervening process, what has come to be known as cognition, or how an individual works out in their own way what is going on.[13] A pure behaviourist might argue that an individual's cognitive processes have become what they are as a result of behavioural shaping over a long period of time, but that is an argument susceptible to *reduction ad absurdam*.[14] Cognitive behaviour therapists do acknowledge that behaviours have consequences that can alter the understanding of the conditions that may have elicited them, but unlike pure behaviour therapists they are as much interested in how situations and experiences are understood as they are in the associated behaviours. However, in contrast to psychodynamic psychotherapists they regard these patterns of appraisal and understanding, or cognitions, as accessible, definable, measurable and subject to scientific method. Indeed, cognitive science is a well-established field. Although some of the methods might be different CBT can claim to be as scientific as behaviour therapy, and as it also focuses upon measurable outcomes it is subject to audit and can offer visible cost–benefit analyses.

The father of CBT is Albert Ellis, who famously forced himself to talk to 130 women in one month as a way of overcoming his shyness. He observed that as well as becoming more comfortable with approaching women, he also understood what would happen in a different way, and becoming more comfortable with approaching women was associated with a change in how he understood what would happen if and when he did. There was evidence of a close relationship between cognitions (how approaching women was anticipated), the behaviour of doing so

[13] Broadly, cognition is the process by which the sensory input is transformed, reduced, elaborated, stored, recovered and used. The expression has a wide range of applications, from psychotherapy through to neuroscience, but here the term is used to cover how an individual makes sense of a particular set of circumstances.

[14] In philosophy, an argument that if taken to its conclusion proves unchallengeable and therefore also unverifiable.

and the consequences.[15] Ellis was closely followed by Aaron Beck, who introduced the term 'cognitive therapy' in 1963.[16]

The core feature of cognitive therapy is that it addresses unhelpful thinking. Unlike psychoanalysis, which addresses unwanted behaviours and interpretations by understanding them as consequences of unconscious 'forces', or behaviour therapy, which addresses them directly using techniques of behaviour modification, cognitive therapy addresses the thoughts that are understood to underpin them. Ellis drew attention to forms of irrational belief that, when applied in everyday life could result in inaccurate and unhelpful conclusions. Beck drew attention to illogical ways of thinking. Examples of Ellis' irrational beliefs include 'It is a dire necessity for an adult human being to be loved or approved of by virtually every significant person in the community', 'One should be thoroughly competent, adequate and achieving in all possible ways if one is to consider oneself worthwhile' or 'One should be dependent upon others and need someone stronger than oneself on whom to rely'. Examples of illogical ways of thinking highlighted by Beck include (i) 'magnification', emphasising difficulties and failures, (ii) 'selective abstraction', arriving at a conclusion based only on a selection of the evidence and (iii) 'arbitrary inference', arriving at a conclusion despite the absence of supporting evidence. There is no formally defined catalogue or classification of irrational beliefs or illogical ways of thinking, but some or all of them play occasional parts in everyday life. People jump to conclusions, generalise, hold prejudices and don't always take all the evidence into account. Cognitive therapy focuses upon relationships between habitual patterns of illogical thinking and irrational belief, and unwanted feelings and behaviours. A student with a poor exam mark who habitually believed that 'I should be thoroughly competent, adequate and achieving in all possible ways if I am to consider myself worthwhile' and was therefore prone to 'magnification' might be particularly distressed. They might overlook the fact that they

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[15] In 1982, Albert Ellis (1913–2007) was ranked as the second most influential psychotherapist to date (Freud was ranked third). In 1962, Ellis published his cognitive behavioural views under the name of 'rational emotive therapy' (Ellis, 1962).

[16] Aaron Beck (b. 1921) published *Depression: Clinical, Experimental and Theoretical Aspects* in 1963 (Beck, 1963). In addition to co-fathering CBT, another legacy has been the Beck Depression Inventory, a reliable and now widely used self-report questionnaire that provides a measure of depression and which was amongst the first of many such quantitative instruments that are now employed in psychotherapy research.

have good marks from all other courses and they might experience the poor mark as global personal failure, rather than not doing as well as they might have preferred in one small corner of their life. The characteristic features of depression—unhappiness, withdrawal and loss of interest—might follow as understandable consequences of the resulting inaccurate but strongly held belief, 'I am a complete failure and no one likes me'. A cognitive therapist would identify inaccurate belief(s) that make sense of or explain the misery and withdrawal, and engage in gentle debate with the client over the grounds for coming to such conclusions and whether or not there might be a different way of interpreting what has happened. In our example of the disappointed student, that would obviously involve teasing out the fact that the whole of life doesn't depend upon success in one narrow field, and that poor marks for one module don't necessarily mean failure of the whole course.

Cognitive therapists also place emphasis on the behavioural consequences of dysfunctional thinking. In becoming miserable and withdrawn our student will focus upon other imperfections of their life, for instance that they don't have a girl- or a boyfriend at present, that money is tight or that they don't seem to be getting on with their flatmates as well as they would like to. By withdrawing they won't perhaps share others' experiences of the same exam and find that everyone else found it difficult. They will compound their misinterpretations of what it means to have done poorly in it by depriving themselves of evidence that would put another gloss on what had happened. This aspect of dysfunctional thinking and consequent behaviours is particularly well illustrated by the application of CBT in the treatment of recurrent panic attacks.

Recurrent panic attacks are a particularly disabling condition in which the afflicted suffers episodes of intense anxiety, sometimes several times a day. They are experienced as dreadful fear that some great harm might occur. For many this evolves into a state of affairs in which they go to great lengths to avoid situations where they fear a panic attack might happen. This is agoraphobia, effectively a fear of going out and about unsupported. It has long been recognised as a disabling condition. Initially, behavioural psychotherapeutic approaches focused upon the avoidance and approached it using various schemes of graded exposure or desensitisation. This had only limited success. It became apparent that the afflicted were not so much concerned about being in particular places or situations, but with what they feared might happen to them when there. It emerged that people with recurrent panic attacks were people who had developed a habit of jumping to the conclusion that one of several otherwise unremarkable bodily sensations meant

that they were about to suffer a catastrophic illness. They were of the view that a slightly racing heart meant they were about to drop dead from a heart attack, that a degree of breathlessness meant that they were going to choke and suffocate, that light headedness meant that they were going to suffer a catastrophic stroke or that a modest degree of confusion meant they were going to go crazy and lose control. Given the particularly threatening implications of these catastrophic conclusions it is barely surprising that when they do occur, they are experienced as intensely frightening. Equally, it is barely surprising that all sorts of strategies are developed to avoid situations in which it is feared they might occur, that there is someone to hand who is trustworthy and can get help if needed, or that there is a clear escape route. CBT for recurrent panic attacks has proved to be a highly effective remedy for agoraphobia and related conditions; it is derived from an experimentally developed, comprehensible and sufficient understanding of the condition, and it has been able to demonstrate measurable outcomes in response to specified therapeutic inputs.[17]

CBT has won a considerable following. In large part this is because it can be understood from a scientific perspective. It addresses measurable phenomena such as distorted cognitions, the frequency of panic attacks, symptoms of depression or the level of avoidance behaviour, all of which mean that it can be evaluated by conventional clinical trial methodologies. CBT treatments can be standardised and are even available as computer applications.[18] In general, it is relatively brief, occupying some 12–16 sessions. All of these qualities make it attractive to funding organisations, which require auditable measures of efficacy and clear definitions of clientele and the therapeutic process. In the USA and the UK CBT is recommended as a contribution to, if not the preferred treatment for, a very wide range of mental health difficulties from the management of psychotic experiences to depression and anxiety

[17] A cognitive approach to panic was first proposed by Clark and his associates who were able to predict and test for specific cognitive distortions amongst people suffering recurrent panic attacks (Clark, 1986; Clark et al., 1988). Systematic associations between beliefs and safety behaviours were separately demonstrated in two independent investigations (Middleton, 1996; Salkovskis et al., 1996). This experimental work formed the basis of a treatment with predictable and measureable treatment outcomes (Clark et al., 1994). By 2004 CBT had become accepted as the treatment of choice for recurrent panic attacks (McIntosh et al., 2004).

[18] Two UK examples are beatingtheblues® (http://www.beatingtheblues.co.uk/) and FearFighter™ (http://www.fearfighter.com/).

disorders (see Roth and Fonaghy (2006) and Lambert (2013)). However, it is also clear that CBT has its limits. Clinical trial results do not always translate into real-life situations, and practitioners are not always able to limit their interventions to specifically cognitive behavioural techniques.[19] At a conceptual level, understanding mental health difficulties as a result of distorted thinking and learning experiences is barely novel. What proponents of CBT have been able to do is extend the use of scientific methods into the study of distorted thinking and learning experiences. However, these remain embedded in the more complex whole of individual human psychologies and their determinants. To explain how or why distorted thinking and learning experiences happen in the first place, proponents of CBT have to fall back upon developmental interpretations of how particular patterns of distorted thinking may have come about.[20] Although it has proved possible to offer a credible, scientifically derived account of discrete phenomena such as recurrent panic attacks, it becomes much more difficult when habitual and disabling misinterpretations concern less tangible phenomena such as styles of relationship and reactions to particular forms of interpersonal interaction. Derivatives of CBT such as cognitive analytic therapy,[21] dialectical behaviour therapy,[22] and mindfulness therapy[23] acknowledge this need to respect the contribution of unconscious forces to the difficulties

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[19] Careful review of what therapists actually do with clients reveals wider ranges of practice than can be entirely accounted for by narrow cognitive behavioural perspectives. See, for instance, White (2000) and Waller (2009).

[20] Both Beck and Ellis were from a psychoanalytic background and initially saw their approaches as extensions of that tradition. Their divergence from it began primarily with an interest in applying scientific methods.

[21] Developed by UK practitioner Anthony Ryle as an explicit integration of CBT's structured approaches to changing ways of thinking and psychoanalytic insights into what those might be and how they might be responsible for unwanted behaviours and experiences.

[22] An approach developed by Marsha Linehan for the treatment of individuals suffering borderline personality disorder but which has enjoyed wider application as an approach to distress management. It uses a blend of cognitive behavioural techniques, which are used to amend the client's understandings of and reactions to their own emotional states, and psychoanalytic approaches to understanding what they are and where they may have come from.

[23] An approach to reappraising distressing or unwanted psychological experiences with origins in Buddhist meditation. By making a distinction between the experience of mental events and their immanent significance clients are able to acquire a more measured appreciation of their meaning.

they address, but they do so at the expense of becoming less accessible to rigorous scientific evaluation.

Furthermore, CBT is no less dependent upon a satisfactory match between a client's and a therapist's views of the problem and how it might be addressed, than any other form of psychotherapy. It is conducted through the medium of a therapeutic relationship and it is not difficult to see how that may have to be a particularly strong and trusting one. In the course of treating recurrent panic attacks a client might be asked to test their catastrophic interpretation of certain bodily sensations. The catastrophic interpretation is likely to be 'this signals a life-threatening medical condition', such as breathlessness signalling suffocation, palpitations signalling a heart attack or light headedness signalling a stroke. Testing these out in therapy often involves deliberately provoking the feared sensation by exercise, overbreathing or standing up suddenly; in other words, a behavioural experiment. In doing this the therapist is effectively asking the client to engage in something they believe to be life threatening, and that is only going to happen if considerable trust has developed. The success or otherwise with which such a relationship might develop is dependent upon a much more complex set of variables than CBT itself might consider. For instance, someone suffering recurrent panic attacks may be younger or older and they may be male or female. Even these simple distinctions have important effects upon how they are affected and how they might engage with a therapist.

Young women suffering recurrent panic attacks commonly become expressively concerned for their own safety. When this happens to someone still living at home or otherwise quick to call upon family support, continuing dependency of this form results in intense demands upon close family. Such demands are frequently translated into a desperate and often disruptive search for a medical explanation and treatment. The result is a chaotic and anxious family. In young men the same condition is frequently expressed as explosive, demanding help-seeking behaviour. Conventional expectations of manly resilience and self-dependence are threatened by the experience of vulnerability that accompanies panic attacks, and this can lead to the episodic loss of composure and impulsive if not challenging demands for treatment. The result is an angry young man. The older woman, perhaps one responsible for young children, is likely to respond in a different way. For her there are tensions between her own insecurity and her need to support and provide for others. These tend to find expression in a

more secretive experience of panic attacks and to the development of strategies such as the characteristic avoidance pattern of agoraphobia. This might provide a sense of control over the situation, but only at the expense of important domestic tasks such as shopping independently or providing school transport. Such impairments have an obvious impact upon family life and marital harmony. The older man and perhaps the older woman whose life is not rooted in family responsibilities might guard themselves from the risk of occupational disgrace by secretively developing reassurance-seeking strategies, such as a dependence upon medication, social avoidance or a highly structured routine. In their own ways these bring their different social costs. It is not immediately obvious that the clamouring, frightened teenage girl and her family, the angry explosive young man, the dependent, worried and scurrying housewife, the defensive, somewhat reclusive and rigid older man, or the forthright and apparently successful career woman with a bottle of Valium® tablets in her handbag are all suffering from the same condition. It is equally unlikely that all five of them will have the same understanding of their needs and difficulties, as might be the case if all five of them had a broken leg. Furthermore, each of them will be associated with other people in very different ways, and in ways that vary in the extent to which others will be supporting their strategies of avoidance. Their recurrent panic attacks will only become susceptible to the structured approach of a cognitive behaviour therapist when and if negotiation and relationship building have enabled the problem to be seen in an appropriate light by all relevant participants. The real-life conduct of CBT involves far more than simply applying scientific findings.

Behavioural and cognitive behavioural approaches to psychotherapy have played a valuable part in demonstrating that certain forms of unwanted behaviour can be understood from a scientific perspective, and that has given them respectability in a broader climate, which is dominated by respect for the scientific method. As a result, they enjoy wide popularity but there are clear limits to the extent to which scientific approaches can and do explain all that CBT and its derivatives achieve, or predict where they might be effective. The behavioural and cognitive behavioural enterprise has introduced scientific methods to psychotherapy research and has notable achievements. Arguably, it has also begun to identify the limits of a strictly defined scientific approach to this field. Even CBT has to accommodate the complexities of human relationships and the individually determined development of their

determinants, and from some points of view these cannot be addressed 'scientifically'.[24]

Humanistic–existential and Transpersonal Approaches

Humanistic–existential and transpersonal psychotherapies constitute a third distinct psychotherapeutic perspective. Psychoanalytic and cognitive behavioural approaches share a focus upon correcting a fault—abnormalities or psychological glitches considered responsible for unwanted behaviours and feelings—although they differ from one another in the ways these are conceptualised. The former sees them as experienced but inaccessible unconscious residues of personal development, and the latter as accessible and identifiable abnormalities of thinking. Humanistic and transpersonal approaches embrace each of these in that they respect a view of the individual as a unique relating human being formed by prior experiences in the same way psychoanalysis does, but, at the same time, they share with cognitive behavioural approaches the view that life is played out in the present and that ways people react reflects the ongoing sense they make of what is around them. Where humanistic and transpersonal approaches differ from both psychoanalytic and cognitive behavioural approaches is in the emphasis they place upon personal growth and development rather than the correction of fault or abnormalities. Instead of viewing the client as a passive recipient of expert help they emphasise clients' choices and inner resources. Therapeutic frameworks that can be considered together under this classification include Carl Rogers' person- or client-centred therapy, gestalt therapy and transactional analysis. Very broadly, all three and their related derivatives focus upon a view of the adult human being as a 'work in progress', someone seeking fulfilment and susceptible to difficulties or mental health problems if and

[24] A strict definition of the scientific method might be one that embraces Popper's doctrine of testability. Science is the use of experimental procedures designed to elucidate whether or not the behaviour of matter or other phenomena conforms to a specific prediction. 'On the basis of what I already know about this subject I believe (hypothesise) that if I measure or perturb it in a specified way certain predictions will be fulfilled'. This depends upon the subject of enquiry being something sufficiently stable across time and situations to allow specific predictions to be made. Unique, individual phenomena that are emergent from a set of complexities such as an individual human life or the relationships that embody it do not hold such properties except, perhaps, to a first level of approximation.

when that progress is disrupted or hindered. In this respect humanistic and transpersonal approaches share a lot of intellectual territory with existential and theologically orientated philosophies. They have much in common with supportive and caring interactions that are found across the full range of human experience, such as love, friendship, wise counsel and spiritual guidance. As a result, practitioners of humanistic and transpersonal approaches have found it difficult to fit into professionalised, technique-oriented formal mental health services, but that appears to be changing. Growing emphasis upon recovery as a therapeutic goal focuses upon clients' strengths and capacity to own their difficulties (see, e.g., Repper and Perkins (2003) or Pilgrim and McCranie (2013)), and in the UK concerns about the rise of dependency upon formal mental health services and the use of psychotropic medications has encouraged the National Health Service (NHS) to invest in readily accessible counselling.[25]

Carl Rogers is the name most closely associated with these approaches.[26] The foundation of his approach is the notion of *actualising tendency*: human beings' natural motivation towards constructive growth and development. He described it as:

> the urge which is evident in all organic and human life—to expand, extend, to become autonomous, develop, mature—the tendency to express and activate all the capacities of the organism, to the extent that such activation enhances the organism or the self (1961, p. 35).

Rogers saw the actualising tendency progressing satisfactorily through childhood and into adult life provided that the individual is able to grow in an atmosphere of 'unconditional positive regard'; in other words, an experience of being valued as a person independently of whom or what they are. Under these circumstances the adult will be someone 'comfortable in their own skin' and relatively resilient to the challenges of life. If, instead, the child grows in an atmosphere of conditional regard, one in which they experience themselves as only

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[25] In 2006 the NHS began a process of improving access to psychological therapies, which was providing universal adult access to a range of therapies by 2010. The scheme is organised as a stepped-care model whereby relatively uncomplicated difficulties are provided for by short-term support administered by counsellors who may not have advanced professional qualifications.

[26] American psychologist (1902–87).

valued if certain conditions such as behaving well, working hard at school or containing emotions are met, then they will develop into adult life dependent upon having to fulfil such conditions if they are to feel good about themselves, and vulnerable to mental health difficulties if they are unable to. Therapy is provision of a relationship in which the client can experience unconditional positive regard and discover that there is no need to fulfil pre-set conditions before self-actualisation and personal growth can be experienced. Rogers (1957) identified six specific conditions that he believed had to be met before a therapeutic encounter could achieve this. They are:

- two persons are in psychological contact
- the first person, the client, is in a state of incongruence;[27] vulnerable or anxious though not necessarily aware of this
- the second, the therapist, is congruent,[28] or integrated in the relationship
- the therapist experiences unconditional positive regard for the client the therapist experiences an empathic understanding of the client's internal frame of reference and attempts to communicate this experience to the client
- the communication to the client of the therapist's empathic understanding and unconditional positive regard is achieved, if only to a minimal degree.

Rogers regarded these conditions as both necessary and sufficient for an encounter to result in helpful and perhaps healing change. The presence of psychological contact refers to mutual and reciprocal awareness of feelings between participants. Incongruence identifies one of them as troubled and seeking better understanding of themselves, whereas congruence reflects the role of the other as the advisory, helping party. The therapist experiences unconditional positive regard for the client, and an empathic understanding of their difficulties and frame of reference. These are developed through exploratory conversation and they are explicitly and implicitly communicated to

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[27] Incongruence refers to an incompatibility between underlying feeling and awareness of those feelings, or an incompatibility between awareness of feelings and the expression of feelings. Incongruence would be recognised in someone who appears anxious but does not recognise this in themselves, or in someone experiencing anxiety but not able to express it in a meaningful way (see Mearns and Thorne, 1999).

[28] The opposite of incongruent. Aware of their own feelings and able to express and understand them.

the client. Experience of a relevant, understanding and unconditionally supportive relationship is sufficient to enable constructive change. The direction of change is not predetermined or set against external measures of what may or may not be considered the difficulties to be overcome or shortcomings to be corrected. Rather, these sufficient relational conditions provide a psychological environment in which natural personal growth and development are enabled, and the direction that it takes is bespoke and individual. It is self-actualisation, and, as such, it is in a positive, social and constructive direction.

Unsurprisingly, this approach has attracted a lot of criticism. In specifying the therapist's role as nothing more than the provision of a conducive atmosphere, Rogers' has been described as a simplistic explanation of people's problems.[29] Furthermore, provision of a supportive empathic relationship is not necessarily confined to specifically psychotherapeutic contexts; exactly the same process can be understood as the essential ingredient of many other forms of helping, healing and supportive relationship.[30] Finally, from a scientist's perspective the core underpinning phenomenon, self-actualisation or actualising tendency is no more available to empirical study than Freud's id, ego and superego. All of these are criticisms predicated upon the assumption that mental health difficulties are exclusively the province of specially trained professionals engaged to rectify psychological abnormalities using techniques derived and verified by science. This might be an unhelpfully narrow perspective.

Other humanistic–existential psychotherapeutic approaches with sufficiently well-established identities to be well known by name are gestalt therapy and transactional analysis.[31] *Gestalt* is use of the German word referring to total configuration, or the notion that the whole is greater than the sum of its parts. Gestalt therapy has much in common

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[29] Nelson-Jones referred to this as 'essentially a single treatment approach … an inadequate way to approach the range of difficulties people have in being personally responsible' (1984, pp. 15–16).

[30] Rogers makes this explicit throughout his work. In *On Becoming a Person* (1961) he acknowledges similarities between his conception of a helping relationship and Martin Buber's *I-Thou* (as opposed to *I-That*) relationship, which Buber (1878–1965), existential philosopher and Jewish theologian, identified as a defining human experience. In 1957 Buber and Rogers famously held a public dialogue concerning these matters, which has been published (Anderson and Crissna, 1997).

[31] Attributed to Fritz Perls (1893 – 1970) and to Eric Berne (1910–70), respectively.

with Rogers' generic client-centred therapy in that it emphasises a view of the client as a responsible, autonomous individual functioning in the real world, although quite possibly hindered by doubt and conflict. In common with Rogers, therapy is principally the provision of a safe and sufficiently robust relational setting in which such hindrances can be explored and, ideally, resolved. It differs from Rogers in that it is more directive and potentially more emotionally challenging. A famous technique is the so-called empty chair exercise in which a significant and troubling other person or someone embodying troubling issues is imagined to be seated. Thus, they are introduced into the therapeutic setting as a 'real' person and the client is encouraged to engage in dialogue with them. This can have the effect of bringing covert internal conflict into the here and now, and enable constructive engagement with it.

Transactional analysis focuses upon incongruent communications. How one might explicitly interact with others, and ways in which what is truly felt or intended might be different. 'How nice to see you', might be accompanied by a tone of voice and other features of body language, which actually reflect something quite different, a more authentic representation of how that interaction is really experienced. Styles of relating are characterised as 'child', 'parent' and 'adult' reflecting patterns derived from childhood, experiences of parental figures of the past and emotionally untrammelled strategies developed in adulthood. This emphasis upon continuing legacies from early life reflects its origins in a psychoanalytic background, but in common with other humanistic approaches transactional analysis is based upon the assumption that at their core people are 'OK' and only hindered by unhelpful patterns of interaction. The task of the transactional analysis therapist is to facilitate the client's understanding of how their habits of interaction reflect the 'inner child', their experience of parental figures and rational, adult strategies, and develop ways in which these can be mastered.

The notion of an individual as an essentially creative entity moving towards fulfilment in the form of self-actualisation has much in common with perspectives upon the human condition that give voice, in one form or another, to the notion of spirituality. An essential and inherently autonomous self is implicit in notions of self-actualisation, personal growth and development, and the effects of influences that might hinder them. 'Self' cannot be understood or conceptualised without reference to ways in which it is constructed and experienced through interactions with other individuals and the wider landscape of

human experience and consciousness.[32] Psychotherapeutic approaches that explicitly embrace this are those that can be subsumed under the general heading of 'transpersonal approaches', and notable amongst these is the contribution made by Abraham Maslow.[33] He described self-actualized people as those who

> listen to their own voices; they take responsibility; they are honest; and they work hard. They find out who they are and what they are, not only in terms of their mission in life, but also in terms of the way their feet hurt when they wear such and such a pair of shoes and whether they do or do not like eggplant … All this is what the real self means (Maslow, 1993, p. 49).

Viewed from this perspective a self-actualized person, or in Carl Rogers' terms, a fully functioning person is one who is comfortably in a relationship with themselves, their human and their wider material and symbolic environments, and therapy is regarded as a process that enables progress towards this goal. Other writers associated with this perspective include Carl G. Jung after his divergence from Freud and his development of ideas conceptualising collective unconsciousness, Stanislav Grof who was a close friend of Maslow's, and Ken Wilber who has found similarities between these frameworks and Eastern religions. Transpersonal approaches have many adherents who testify to the value of moving beyond the constraints of scientific method if the purpose is pursuit of personal growth and healing, and to the parallels between 'psychotherapy' and ancient practices embodied in religious rituals, counsel and scripture. Conceptual and procedural similarities between humanistic–existential and transpersonal psychotherapies, and facilitated personal or spiritual growth, make them attractive amongst some

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[32] This text is not the place for a full discussion of contemporary approaches to conceptualising 'self'. Contributions include the work of G.H. Mead (1934), Blumer's development of the methodological framework, symbolic interaction (Blumer, 1969), and Jenkins' *Social Identity* (2008). Roe (2013) provides an example of their application to the study of mental health difficulties.

[33] Abraham Maslow (1908–70) was identified with Maslow's hierarchy of needs, which is a way of outlining individual fulfilment as progress through the fulfilment of more basic and physiological needs such as food, drink and sexual appetite, needs for safety, needs for love, acceptance and belongingness, needs for esteem, approval and recognition to self-actualisation originally described in 'A Theory of Human Motivation' (Maslow, 1943).

constituencies, and a source of concern to others. They focus upon phenomena such as individuality, autonomy and self-hood that are not conventionally subject to systematic measurement or scientific method, but do have currency in everyday life and cultural traditions.

Three Partial Perspectives and a Broader One

Psychoanalysis and its derivatives have given life to the concept of psychotherapy as an explicit, professionalised exercise in psychological healing. Behavioural and cognitive behavioural approaches reflect the application of scientific methods to the field and, from some points of view, illustrate the limits of a narrowly defined 'scientific' approach. Humanistic–existential and transpersonal therapies complete the circle and can be considered a contemporary application of historically long-standing, intuitive and yet unscientific approaches to alleviating human emotional distress and difficulties. Each makes its own separate contribution to a larger picture, but none provide it in full. Like the blind men who went to 'see' an elephant,[34] or, more formally, from a critical realist's epistemological position,[35] each provides its own particular insights into and recommendations for the conduct of interpersonal emotional healing, but all fall short of the full picture because, in practice, what happens cannot be fully explained by any one of them. Much of the help and healing mental health services provide happens outside of psychotherapy, if psychotherapy is narrowly defined as specifically organised regular sessions involving a therapist, and one or more clients following a particular theoretical approach. Although practitioners may begin a career specialising in a particular approach, it is common for the more experienced practitioner to be one who combines different

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[34] The allegory of several blind men who encountered an elephant for the first time, one feeling a leg and exclaiming 'It is like a tree', another, the side and exclaiming 'It is like a wall', and another the trunk and remarking 'It is a snake'. Each has only a partial perspective and none can appreciate the whole.

[35] Critical realism is an epistemological approach that spans the extremes of committed positivism (there is an external reality that scientific method can define) and committed constructivism (everything experienced and shared by humans is nothing more than a construction of the human mind), by arguing that an external reality can be experienced in part, but only partially and in ways determined by the techniques of investigation and perspectives chosen by the observer. This approach to knowledge is formally attributed to Roy Bhaskar (1975/2008).

approaches in a flexible manner (see, e.g., O'Hara and Schofield, 2008). Finally, it has been long recognised that differing psychotherapeutic approaches share common processes, which may account for their outcomes better than their individual techniques. A contemporary account of psychotherapy has to include a wider perspective that takes these overlaps and partial explanations into consideration.

Lewis Carroll's fictional Dodo Bird in *Alice's Adventures in Wonderland* famously declared that '*Everybody* has won, and *all* must have prizes'. This expression was taken up by Rosenzweig in a 1936 paper, which discussed the possibility that the outcome of psychotherapy might reflect influences common to all forms of therapy rather than effects directly attributable to the particular technique or theoretical position taken by the therapist in question.[36] This has come to be recognised as the most appropriate way of understanding similarities and differences between psychotherapies. A series of reviews and meta-analyses of outcome data over the last half century all broadly agree. The first was published in the 1970s (Luborsky et al., 1975), and others have followed.[37] The 'dodo bird verdict' has an established place in the language of psychotherapy research, and its implications are profound. In statistical terms there is no detectable difference in efficacy between differing psychotherapeutic approaches, and what does appear to influence outcome is the operation of several so-called common factors. These have been variously articulated, most famously by Jerome D. Frank:[38]

- an intense, emotionally charged, confiding relationship with a helping person, often with the participation of a group
- a rationale, or myth, which includes an explanation of the cause of the patient's distress and a method for relieving it

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[36] Rosenzwieg concludes his discussion as 'it may be said that given a therapist who has an effective personality and who consistently adheres in his treatment to a system of concepts which he has mastered and which is in one significant way or another adapted to the problems of the sick personality, then it is of comparatively little consequence what particular method that therapist uses' (1936, pp. 414–15).

[37] Notably, these include Wampold et al.'s (1997), Stiles et al.'s (2008) and Budd and Hughes' later commentary (2009).

[38] Frank (1961) outlines these in *Persuasion and Healing* and they were further articulated in 1971 (Frank 1971). Fischer et al. (1998) offer a more condensed description, taken from a multicultural perspective.

- provision of new information concerning the nature and sources of the patient's problems and possible alternative ways of dealing with them
- strengthening the patient's expectations of help through the personal qualities of the therapist, enhanced by his/her status in society and the setting in which (s)he works
- provision of success experiences which further heighten the patient's hopes and also enhance his/her sense of mastery, interpersonal competence or capability
- Facilitation of emotional arousal, a prerequisite to attitudinal and behavioural changes.

It is not difficult to see how each of the three main psychotherapeutic approaches emphasise some of these common factors, or how an 'ordinary' helping relationship with someone of the right personal qualities and motivation but who may not be acting in an explicitly psychotherapeutic role might also provide them. Psychoanalysis pays particular attention to the intense feelings (transference) a client may develop towards their therapist, and the relationship between client and therapist is also an acknowledged and central feature of the humanistic–existential approach. Most notably, CBT provides a rationale explaining the client's distress and offering ways of relieving it, but the other approaches also do this in their different ways, and the same is true for the provision of new information. Through their status and qualifications all formal psychotherapists, and other professional mental health workers, offer expertise and philanthropic authority. Humanistic–existential approaches place particular emphasis upon clients' personal growth, hopes and interpersonal competences, although an atmosphere of hopeful expectation has to be a feature of all successful psychotherapeutic interventions. Finally, the experiential experiments of CBT, analysis of transference and defence mechanisms in the course of psychodynamic psychotherapy, and the identification of self-defeating strategies during a humanistic–existential therapy are all challenges to the client's status quo. They encourage uncomfortable risk taking in the pursuit of change, which is only likely to happen if the therapist is able to engage positively with clients' heightened emotions. Ways in which 'ordinary' helping relationships incorporate the same qualities and processes are illustrated by some of the words used to described them: 'A shoulder to cry on', 'Reliable and trustworthy', 'They know what they are talking about', 'Helped to put things in perspective', 'Challenging', 'Insightful', and so on.

'Psychotherapy': A Bigger Picture

There is abundant evidence that mental health difficulties are associated with social dislocation and challenging circumstances.[39] Against this background it is clear that various forms of practical and relational support delivered in everyday settings, rather than as formal 'therapy', are greatly appreciated by those who receive them. Whether or not these activities are considered 'psychotherapy' is no more than a semantic question, one of definition. When provided by mental health services they amount to helpful interactions between mental health workers and their clients. Primarily, they are the activities of qualified community staff organised as teams and employed by formal health service provider organisations, but they also include the activities of unqualified employees and volunteers. If all of these activities are considered 'informal' psychotherapy then most organised mental health services provide more assistance in this way than they do as 'formal' psychotherapy.

Community mental health teams date from the latter days of the large asylums and their closure. Many of those who were discharged to community settings were considered vulnerable and potentially disruptive, and in need of continuing care in their new setting. Furthermore, the stability of many was considered to be dependent upon them remaining medicated. Long-acting depot neuroleptic medications were in widespread use and the role of the community psychiatric nurse was readily established, as one who visited a case load of individuals on a regular basis to both keep an eye on how they were and administer a depot injection. As the following decades have passed this role has developed and it now embraces a wider range of functions. The majority of people now engaged with formal mental health services at any one time are resident in community settings, and a considerable proportion of these are regularly visited by a community mental health worker who may be from a nursing, occupational therapy or

[39] For instance, Emile Durkheim (1858–1917) drew attention to associations between suicide and the lack of social ties (Durkheim, 1897), Faris and Dunham (1939) described social class differences in the prevalence of schizophrenia in 1920s Chicago, Hollingshead and Redlich (1958) identified interactions between sociocultural factors and individuals' thoughts, feelings and behaviour in the 1950s, and Brown and Harris (1978) demonstrated causative links between adversity and the onset of depression amongst London women in the 1970s. More recently, associations have been found between the development of psychosis and growing up in socially dislocated circumstances (Morgan et al., 2008), and across developed countries there is a strong relationship between the prevalence of mental health difficulties and income inequality (Pickett and Wilkinson, 2010).

social work background. In many places these mental health workers are organised into teams that specialise in providing for different sets of clientele or different types of problem. Thus, in most UK districts there will be a Crisis Resolution Home Treatment (CRHT) team, an Assertive Outreach (AO) team and an Early Interventions for Psychosis (EIP) team alongside the generic Community Mental Health Team.[40] Other jurisdictions have different but comparable arrangements. CRHT teams provide round-the-clock cover and are available to support clients in acute difficulty who might otherwise have been admitted to hospital. AO teams provide for those who are a particular source of concern to others and might be reluctant to accept mental health services. EIP teams provide for young adults who are showing early signs of psychosis, which might be prevented from developing into more severe and enduring difficulties by intensive intervention. In some districts there might be a team specifically commissioned to provide for women towards the end of pregnancy and into the first year of the infant's life. There may be a team specifically focused upon providing for people primarily troubled by alcohol or substance misuse, and in most of the UK children under the age of 18 years and adults over the age of 65 years are provided for by specialized Child and Adolescent Mental Health Services and Mental Health Services for Older People respectively. In other words, the body of a contemporary mental health service is a family of community teams whose work is to develop and maintain contact with clients suffering a variety of mental health difficulties and resident in community settings. These contacts might support the regular use of medication and even include administering a depot injection, but that is no longer their primary aim. Their primary aim is to provide a supportive relationship and facilitate what can be a complex set of interventions.

Someone seriously disabled by mental health difficulties might be limited in their ability to address financial problems, difficulties with childcare, legal challenges, problems with tenancy or home ownership or needs to attend to additional health problems. In the UK this is recognised and addressed by administering services under a framework known as the Care Programme Approach (CPA). CPA reflects a formal Department of Health stipulation that anyone with mental health difficulties that merit several different forms of intervention should have an identified care coordinator whose job it is to do just that, coordinate

[40] These specialised teams were developed by the NHS in the UK as a programme of mental health service reforms implemented during early years of the twenty-first century (Department of Health, 2001).

the various inputs. Although the setting is different, the value of such a role is also recognised by American healthcare provider organisations.[41] The care coordinator has to be someone with sufficient experience and, where the clientele demand it, from a professional mental health background. Their core task is to develop and maintain a relationship with each of their clients in order to ensure that intended programmes of care are realised and kept under review. This is achieved through regular contact and liaison, the arranging of review meetings and any other tasks that might be necessary to support the client's care plan. For many clients their coordinator represents a critically important, supportive and stable relationship. Simultaneously, it can be a conduit to financial help and advice, accommodation, and mediation with authorities, friends and family.

In their early years community mental health teams kept conventional office hours. Each client had their own key worker who was available to them during those hours. For a number of self-evident reasons this was unsatisfactory and services have embraced a pattern of extended hours' availability, with some such as the CRHT teams providing a 24-hour service. This depends upon shift working and a sharing of responsibility for individual clients between team members. As a result, from the client's point of view their relationship might not be with just one individual mental health worker, but perhaps with two, or even a relationship with several members of the team, as might be the case with someone in acute difficulties who is being visited several times a week. This has implications for the team itself and it also introduces a variety of mental health workers who may have fewer professional qualifications than formally appointed care coordinators. Most community mental health teams include a number of care assistants who are able to make considerable contributions to clients' support and other needs more on the basis of their personal qualities than as a result of formal, professional training. A great deal of contemporary mental health work takes the form of building and maintaining relationships with clients in ways that are not formally 'psychotherapy', but nevertheless play an important part in assisting them through life's vicissitudes, encouraging them to address their difficulties and feel sufficiently safe or sufficiently

[41] In 2012 the American Nursing Association published a white paper advocating the role (American Nursing Association, 2012), and reasoning behind this is also spelled out by Robinson (2010).

well disposed to other more formal therapies to access them.[42] It is clear from these 'social' interventions that much can be achieved by simply providing a supportive and trustworthy relationship. Insofar as the term refers to assisting someone with a mental health difficulty, 'psychotherapy' need not be confined to the consulting room, or to the formal exercising of a theoretically sophisticated technique. Research and theorising suggest that it is relationship and empathic understanding that sit at the heart of successful therapy, and this is what so many mental health workers provide, something that is illustrated by an investigation of clients' experiences of CRHT teams. Those who experienced the team as providing safety, understanding and acceptance benefitted and appreciated the team's input. Interactions in which any of these were hindered for any reason were experienced as unhelpful,[43] just as would have been predicted by consideration of Jerome Frank's common factors.

To Conclude

Contemporary reflections upon psychological therapy boil down to three related and convergent conclusions. Firstly, the most important and essential ingredients of all formal psychotherapeutic encounters are certain common factors. Secondly, these common factors resonate very strongly with the qualities of everyday, otherwise mundane helping relationships. Thirdly, the same common factors are also the important and essential qualities of 'informal' but professionally orchestrated psychotherapeutic encounters. The point of convergence is, of course, that all human relationships have the potential to be nurturing and helpful

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[42] Priebe et al. (2011) and Farrelly et al. (2014) have reviewed and contributed to data relating to the quality of therapeutic relationship to clinical outcome amongst patients with psychosis managed by community mental health teams and find evidence for an effect. However, this research demands clearer definitions of what forms a 'good' relationship might take in this context.

[43] Interviews were conducted with 36 erstwhile CRHT clients who had experienced short-term and usually ad hoc interactions with mental health professionals. Biases due to power relations and other distorting influences were minimised by employing interviewers who had experience of using mental health services and could identify themselves to interviewees as co-service users. Interview transcripts were analysed in parallel by service users and a professional qualitative investigator. Both found the same themes, that helpful provision was a relationship with the team that instigated safety, understanding and acceptance, and unhelpful provision was a relationship that failed on one or more of these counts (Middleton et al., 2011).

if certain conditions are met. Professionally orchestrated relationships can be, and often are, healing encounters because they have the potential to incorporate these conditions and related processes. Professionally orchestrated relationships also have other qualities that enable them to realise healing conditions where and when everyday relationships cannot. They have merit because they are professional. They can operate more or less independently of clients' everyday relationships, which amongst many with mental health difficulties may have broken down and become a source of alienation. They have an authority that transcends the uncertainties inherent in all forms of emotional or psychological difficulty, and because they are provided by a compassionate but otherwise disinterested third party they can be unconditionally accepting and supportive. They are commonly offered by people with authority to intervene with other related professionals and bureaucracy, and thereby support direct practical actions. Specific theoretical frameworks and techniques might be of value in particular situations such as addressing safety behaviours in someone disabled by anxiety or in elucidating the fuller meaning of psychological defences troubling someone with personality difficulties. However, the relationship might be sufficient in itself to enable inherent processes of self-actualisation realise natural healing. Research unravelling the determinants of natural psychological growth and recovery, self-esteem and happiness is a burgeoning area (see, e.g., Mruk, 2013), but whatever its findings and developments might prove to be, it is clear that therapy is only effective when it occurs in the form of a true meeting of minds. Clients' circumstances and expectations play a large part in determining what that might be. A valued mental health professional is someone primarily oriented towards reading clients' circumstances and expectations with a view to developing that healing relationship, and only secondarily attached to a particular approach or school of psychotherapeutic thought. What different approaches or schools of therapeutic thought do influence is the therapy's reputation. In the world of commissioned services, whether purchased by the state on behalf of taxpayers or by an insurance organisation on behalf of contributors the narrow perspective of demonstrable cost-effectiveness plays a pre-eminent part in determining that reputation. Given the importance of complex, immeasurable factors in what actually happens amongst helping relationships of all sorts, this might be an unhelpful distraction from attending to, and commissioning for, what compassionate care and understanding are actually all about.

6
Public Service Psychiatry as it Really is

Chapter 2 identifies how it is that the medical approach to mental health difficulties is as much if not more the result of a play on words as it is an accurate use of them. Chapter 4 has shown that there are better ways of understanding why drug treatments work, when they do, than simply attributing their effects to their chemical properties. This includes taking account of the human and relational dimensions of when and how they are prescribed. Chapter 5 concluded an outline of psychological treatments with an acknowledgment of how important the quality of relationship is in determining their outcomes. Together these open up the need to think about psychiatry from a different, less medical perspective. That perspective can be grounded by standing back and looking again at what psychiatry is actually called upon to do.

If the 'diagnostic' entities defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) Chapter V don't represent the effects of diseased tissue or abnormally functioning organs in the way medical conditions do, then what are we dealing with? Many have tried to answer this question, and the outcome always seems to be circular. 'Mental Disorder is that which is defined as Mental Disorder.'[1] If the working truth of

[1] Bolton (2007) provides a critical reflection upon the limits of normative, naturalistic and deviance-based definitions of mental or psychological abnormality. He concludes that a generic distinction between mental normality and mental abnormality cannot be established without reference to the social or personal context within which it is operating. A condition such as depression or schizophrenia can be defined on the basis of diagnostic criteria, but identifying it as an abnormality is only possible on the basis of statistical probability (it is unusual),

this is accepted, then a more honest exploration of 'mental illnesses' and the services that provide for them can become an exploration of 'what are considered to be mental illnesses' and services that provide for them. Furthermore, the discussion can also begin to embrace questions such as 'Who defines a condition as mental illness or disorder?' and 'To what end and with what authority does this happen?' In other words, a more practical starting point might be to leave philosophy behind and consider what is actually happening on the ground, in practice, in everyday settings.

Referral Letters

One of the defining features of healthcare systems is the practice of referral between practitioners. If and when the demands of a particular case are considered beyond the formal capabilities or resources available to the practitioner currently dealing with it, then they will usually refer the case to another practitioner or clinical facility considered capable of providing what is needed. Such referrals usually take the form of a letter or some other form of communication, which outlines the clinical problem as the referrer understands it, and why they are asking that another clinician with more suitable expertise or access to more appropriate resources becomes involved. Such 'referral letters' are a core feature of all healthcare systems, and they provide a record of reasons why cases are considered beyond the expertise or capability of one part of the system and more suitably addressed by another.

In the UK National Health Service (NHS) a critical step in this process is referral from a general practitioner (GP) to a hospital specialist, or as is now more widely expressed, from primary to secondary care. Such a referral represents a decision on the part of the general or primary care practitioner that the case requires specialised medical expertise, which

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it is disturbing (causes unwarranted distress) or it is considered unwelcome (socially deviant). All of these are relative judgements and, as such, none are able to identify the condition as an abnormality on the basis of an externally validated reference point. Definitions of truly medical conditions are organised around knowledge of their underlying pathology, which does provide a set of external reference points. Such knowledge is not available to psychiatry. For further clarification see Chapter 2.

they do not have, access to technology or resources only available in secondary care settings, or it is a genuine clinical conundrum they are having difficulty understanding. Insurers financing non-NHS healthcare in the UK and the full range of healthcare in other jurisdictions might enable self-referral directly to a specialist but even outside the UK NHS, referral from a primary care physician to a specialist is a commonly encountered step in patients' journeys.

Letters or other communications forming the traffic of such referrals outline reasons behind them. As far as psychiatric difficulties are concerned, referral from primary care to secondary mental health services can be considered the point at which a case formally becomes one identified as 'mental illness'. By far the largest proportion of individuals seeking assistance with emotional and/or psychological difficulties from health services are provided for exclusively in primary care settings.[2] It is only the small proportion referred on to secondary mental health services who are identified as in need of special psychiatric skills and facilities, and are fully exposed to the risks of stigma and social exclusion that accompany the status of psychiatric patient. Letters constituting such referrals incorporate the reasons why such referrals have been made. As a result they are, therefore, a *de facto* record of why primary care practitioners choose to consider particular individuals as cases of 'mental illness' meriting the attention of specialised services commissioned to provide for it. They provide one way of considering how, in practice, an individual comes to be considered someone in need of specialised mental health service input. Whether or not this amounts to a definition of 'mental illness' can be debated, but it is a development in a patient's relationship with healthcare practitioners that can have profound implications, and certainly confers that status in practice.

Formal scrutiny of such letters has shown that the decision to refer an individual from primary to secondary care mental health services is rarely based upon a formal ICD or DSM diagnosis, or a clearly

[2] The National Institute for Health and Clinical Excellence published their Clinical Guideline 123 in 2011, which gives recommendations concerning the identification and management of common mental health disorders by primary care practitioners. It claims that 'the vast majority (up to 90%) anxiety and depressive disorders that are diagnosed are treated in primary care' (National Institute for Health and Clinical Excellence, 2011).

articulated expectation of the specialist input that is being requested. Instead, letters appeared to justify referral on the basis of significant social disruption and distress.[3] This suggests that reasons other than diagnostic criteria determine whether or not an individual's difficulties will result in referral to specialised mental health services and socially locate them as a 'psychiatric patient'. The remainder of this chapter uses illustrative referral letters as a route to identifying difficulties and situations that result in a referral to mental health services and thus, to all intents and purposes, conferring the status of 'psychiatric patient' upon the person so referred. Examples have been drawn from experience of the UK NHS but there is no *a priori* reason to believe that what is conveyed in comparable communications in other healthcare systems that also conform to the 'Western' model, or the reasons individuals self-refer to a psychiatrist when they do, are substantially different.

Most UK NHS secondary mental health services consider referral letters from primary care practitioners in the course of a multidisciplinary meeting where decisions can be made concerning referrals' suitability and most appropriate destination. Some, for instance, might be understood as a difficulty best responded to in the form of an initial

[3] Publication of DSM III was followed by a series of surveys in the US, UK and Australia, some of which have already been referred to, seeking the epidemiology of conditions it defined (Robins et al., 1984; Jenkins et al., 1997; Andrews et al., 2001a). Broadly, and unsurprisingly, these found that they were higher than could be accounted for by the numbers of people receiving treatment, and the view developed that 'mental illnesses' form a large and largely unaddressed pool of untreated illness (Bebbington et al., 2000; Andrews et al., 2001b). This appeared particularly pertinent in the case of depression where treatment with antidepressant medication seemed a readily available and effective option, and it generated a number of initiatives. The most prominent UK example was the 'Defeat Depression Campaign', opened by the Royal College of Psychiatrists in 1992. It had three broad aims: educate health professionals, particularly general practitioners, about recognition and management of depression; educate the general public about depression and the availability of treatment in order to encourage people to seek help earlier; reduce the stigma associated with depression. In relation to the first, several programmes of practitioner education were developed. All proved relatively ineffective in altering practices or in improving clinical outcomes (Thompson et al., 2000; Croudace et al., 2003). This was the background to a formal content study of referral letters, which sought to determine whether the provision of referral guidelines reflecting ICD/DSM diagnostic criteria influenced the wording of such letters (Shaw et al., 2005). It didn't, drawing attention to the fact that expressed reasons for referral to UK secondary mental health services are rarely a reflection of diagnostic criteria. They are most usually other features of the presenting difficulty.

assessment by a psychiatrist. Others might suggest that counselling, or another form of psychological treatment, would be most helpful and yet others suggest the need for a visit from a member of the community mental health team. The usual practice is for representatives of teams providing for a defined locality to meet every week, and consider all the referrals that have come to mental health services providing for that locality during the preceding seven days. Localities vary in size but a representative one might embrace a population of 300,000–400,000 working-age adults, resulting in some 20–30 referral letters to consider on each occasion. Regular participants in such meetings acquire considerable familiarity with what such communications do and don't say. The examples that follow are drawn from the experience of regular attendance at such meetings. Every effort has been made to reproduce the style and contents of actual letters but, of necessity, these illustrations are contrived in the interests of client confidentiality. Nevertheless, they reflect what actually happens in a contemporary UK NHS mental health service, and quite probably in similar settings elsewhere.

An important point is that these examples have been developed in order to illustrate reasons why people are first referred to mental health services; reasons why a GP or another healthcare professional has decided that developments in someone's life mean that they should be considered a case of mental illness. In particular, these illustrations are drawn from experience of considering cold or nonurgent referrals. Situations demanding more urgent action by mental health services are provided for in other ways, by crisis teams, the police, and accident and emergency (A&E) departments. By far the largest part of this more urgent work relates to individuals who are already associated with mental health services and therefore already identified as suffering mental illness, and are getting into difficulties once more. Totally unheralded, seriously disturbed behaviour does occasionally arise. When that happens mental health services are generally involved, and the event is invariably identified as an episode of mental illness. What follows are examples of the much greater number of somewhat less urgently pressing situations in which a call might be made to consider it evidence of mental illness.

This is an example of such a referral letter, from a GP (primary care) to secondary mental health services:

> Many thanks for seeing this 20-year-old woman (Ms A), who has been seeing us over the last few weeks with a history of feeling low

> and depressed. She is currently (approximately 20) weeks pregnant and lives with her boyfriend. She tells me that her boyfriend also suffers with depression and she has found him very unhelpful at times with daily chores at home. This has resulted in arguments, during which she has lost it several times and ended up being short tempered and very, very tearful. She feels that all of this has come from the fact that when she found out she was pregnant, she told her father, and he completely disowned her and told her that he didn't want anything to do with her.
>
> She is struggling to cope at the moment. She used to have appointments with a psychiatric nurse 3–4 years ago for similar changes in her mood. She has requested counselling and I would be grateful if you could see her. She is not taking any medication.

Immediately, several issues emerge. The referral appears to have been prompted by a crisis in family relationships, although problems have been evident for some time and the GP has been attempting to help for 'a few weeks'. Ms A is identified as legitimately vulnerable (pregnant). Although the expressions 'feeling low and depressed' and 'changes in her mood' are used there is no attempt to draw upon the ICD or DSM diagnostic framework, even though reference is made to the fact that Ms A has received help from mental health services in the past. Overall, what is presented is not information indicating that Ms A is suffering an ICD- or DSM-identifiable mental illness. What the letter provides is an account of a difficult and troubling human situation with a number of contributing components. This is characteristic of most such letters and it is difficult to distil distinct themes from them with any consistent validity, other than that they each describe a difficult, distressing and sometimes risky situation. Nevertheless, for the purposes of illustration an attempt has been made to group them around a handful of commonly encountered concerns: disturbing family circumstances involving childcare, threats to safety, consequences of drug and/or alcohol abuse, habitual occupancy of the sick role, repeated anxiety-provoking behaviour, and disturbed or distressing reactions to other healthcare problems. Clearly, more formal research would clarify the validity of these but evidence that that exists is hard to find.

Disturbing Family Circumstances Involving Childcare

Distress in the context of marital conflict and associated childcare is a common reason for referral. Most jurisdictions have statutory

arrangements for the protection of vulnerable children, and these commonly include obligations upon professionals encountering children at risk to act to protect them. Thus, in the hope that children's safety might be improved by acting upon one or more of the parent figures, statutory concerns for children's safety can play their part in precipitating the referral of those otherwise responsible:

> I wonder if it would be possible to refer this man (Mr B) to yourselves, who has had a lot of issues to cope with recently. He had a very acrimonious split from his partner and has also got issues with his new partner's family. He's met a woman and they are currently not living together. She's now pregnant with his first child, her fifth, but her family are not very accepting of him, so this in itself is quite complex and he's just very low, and has been for quite a while. I've seen him today and commenced him on antidepressants.
> I attach a letter from social services who are asking for this referral.

The related letter from child protection services read:

> I am the allocated social worker for Mr B's partner's children, who have a child protection plan. Mr B's partner is currently pregnant by him.
>
> Children's Social Care is concerned about Mr B's excessive alcohol use and aggressive behaviour. Mr B is in the early stages of work with alcohol services. We received a letter from you (GP) on (ten days prior to the date of this letter) confirming that Mr B had suffered an injury affecting his behaviour and balance.
>
> It was recommended at a review child protection conference held on (day before the date of this letter) in respect of Mr B's partner's children that 'a referral be made via the GP for a psychological assessment of Mr B regarding the impact of injury on his ability to parent appropriately'.
>
> I would appreciate if you could make a referral for psychological assessment as a matter of urgency in order to complete a risk assessment of Mr B.

It is illustrative that the letter from the GP does not refer to Mr B's alcohol consumption and identifies him as someone who is 'very low' and in need of antidepressants, whereas the social worker is more concerned about the effects of his alcohol use, aggressive behaviour and possible

head injury upon his ability to act as a parent. Here, in making the referral, the GP is effectively acting as an agent of social services, who are seeking a psychological assessment as part of their child protection processes. The situation is clearly difficult and distressing but the several agencies involved view it from different perspectives, and the referral to mental health services seems to have been prompted by more than one of them.

In other cases concerns about childcare might result in an attempt to recruit mental health services into the situation for even less explicit reasons, calling for speculative interpretations of what is actually going on:

> Ms C has a long history of depression, which she feels is getting worse since she gave birth to a baby girl (ten weeks before the date of the letter). Owing to concerns the baby was taken into care at birth. Ms C was referred to perinatal psychiatry but cancelled her appointment.[4]
>
> Ms C was started on (antidepressant) on (six weeks before date of the letter) but failed to attend for a repeat prescription. PHQ9 score in surgery was 17.[5] I have today re-started her on (same antidepressant).
>
> I have reiterated the importance of attending clinic appointments and taking her medication.
>
> In view of the above I should be very grateful if you would see her for assessment and further management.

Ms C is no more likely to take up a further offer of assistance from mental health services now than she has in the past. Furthermore, the 'long history of depression' had not resulted in specialist mental health service involvement. The perceived need for it now appears to have been precipitated by the birth of her baby girl, and her being

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[4] Perinatal psychiatry refers to mental health services specialised in providing for women towards the end of pregnancy and during the first year of the newborn's life.

[5] PHQ9 (Patient Health Questionnaire) is a self-administered diagnostic instrument for depression. It scores each of the nine DSM-IV criteria as '0' (not at all) to '3' (nearly every day). On the basis of these scores the severity of depression is rated as none (0–4), mild (5–9), moderate (10–14), moderately severe (15–19) and severe (20–27). Copyright is held by the pharmaceutical conglomerate, Pfizer. Controversially, NHS GPs' remuneration for mental health work has been attached to assessments using questionably valid self-report measures such as this one.

taken into care. In other words, there is quite a lot left unsaid. Newborn babies are not taken into care lightly and on reading this letter, experienced mental health practitioners are likely to have speculated that 'long history of depression' actually refers to more troubling difficulties that have threatened or even interfered with Ms C's ability to care for a child in the past. Was this her first child, or had she already had difficulties in this role? A letter like this also conveys strong hints about the client's real interest in accepting medical assistance. Ms C cancelled her appointment with perinatal psychiatry, failed to attend for a repeat prescription and seems to have merited a lecture from her GP on 'the importance of attending clinic appointments and taking her medication'. A response to such a letter would be one balanced between the need for further information from the GP, the sense of urgency it communicates, the fact that Ms C is unlikely to keep appointments and the high probability that she is primarily distressed by the fact that a child has just been taken into care. Whether or not she is taking the right medication, or willing to take any medication at all are minor considerations.

Some referral letters do provide a lot of helpful detail, but quite often in doing so they show how it is that mental health services are being invited to become involved in what might otherwise be viewed as an unfolding human drama, rather than being called upon to assess or treat an illness:

> Thanks for seeing Mr D. He saw me (seven months before the date of the letter) initially having split from his wife and he was rather neglecting himself. Although he had moved out, he told me he was getting invited back for dancing and sex a couple of nights a week, but then his wife announced that she was intending to get a divorce. When he went round, his wife then rang the police accusing him of harassment and he was bailed to appear (six months before the date of this letter). He was very restless and angry but appeared clear headed and I thought he really needed legal rather than medical advice.
>
> He came back a month later telling me that attempts to communicate with his (young) daughter had not gone well. The bail conditions insisted on no contact and, as a result, he was due to reappear in court. Given his agitation I felt he not only needed a solicitor, but might also need a psychiatrist. He didn't want to go to court but it was clearly the only thing he could do at the time because he had broken bail and he stormed out of the surgery. He certainly wasn't

showing any aggression towards me but was making aggressive comments about his wife. It is not really clear what happened over the next couple of months but clearly he was imprisoned for a short time.

He saw one of my partners six weeks ago asking for a note saying that he was unfit to go to court, and then saw me again three weeks later. He stated that his wife had denied him access to his daughter and that he had been let out of prison on the condition that he lived at a distance. He had been formally accused of harassment and a deliberate attempt to cause stress to his wife. He had been told he would not be allowed to come back to (the small town) where she lives, and was banned from the centre of (a nearby city) because his wife works there. We were obliged to inform the police because he had broken his court order by coming to see me (in the aforementioned small town).

I don't think he is psychiatrically well. Because he has had to move away he is rather out of my jurisdiction. I would therefore be very grateful if you could pick him up fairly quickly because I think he has unmet psychiatric needs that are yet to be formally assessed and unpicked from his rather complex social and legal issues.

Mr D is clearly in quite a lot of difficulty but what the GP means by 'unmet psychiatric needs that are yet to be formally assessed' is hard to discern. The problem has been running for more than six months and in any other context it would quite easily have been recognised as a messy divorce. Unfortunately, Mr D has succeeded in recruiting the GP's involvement and it has acquired a medical veneer. Unsurprisingly, things have become worse rather than better and the letter's author is now out of his/her depth. Suddenly, the prospect of 'unmet psychiatric needs' emerges, quite transparently as a justification for passing the problem on up the professional hierarchy rather than dealing with it for what it is.

Threats to Safety

Desperately distressed people commonly resort to desperate measures. These can disturb others and provoke a call for help from mental services. This is a letter from an A&E doctor:

Mr E threatened to hang himself this afternoon and police had persuaded him not to. He came with police informally and wanted help

from our services. He was found upside down hanging from the third floor of the building threatening to hang himself with a rope. He was seen by a passer-by, who called the police, and he agreed to come to the A&E department for informal assessment. Mr E had had an argument with his wife the day before over cuddling his three-year-old daughter. She had objected, left the house and went to her father's house. Mr E felt dejected and tried to contact her this morning but his father-in-law would not let him see the girl. His wife did not want to come back, and that is when he decided to attempt this.

Mr E said that he was not suicidal and did not want to kill himself. He said it was more a 'cry for help'. He wanted to sort himself out and get help. He loves his wife, and he asked her why she did not love him back and he wanted her to come back to him. He spoke to her briefly in the back of the police car when she refused to see him and wanted him to seek help.

Mr E now has no suicidal thoughts or thoughts of self-harm. He described his mood as being 'all over the place' lately, and has had no appetite or sleep problems. There were no other unusual thoughts noted regarding his relationship with his wife. They have been married for a year and two months, and have been together for six years. There have been problems and frequent arguments in the relationship, and Mr E described an incident last week when his wife had taken an overdose and social services were involved.

He described his mood subjectively as all over the place and objectively he was euthymic.[6] There was no formal thought disorder, delusions or any other perceptual abnormalities. No thoughts, plans or intent of self harm or suicide were present. His insight was good; he appeared well motivated and willing to engage with services. No cognitive deficits were noted. Risk of self-harm, suicide, harm or self-neglect, and vulnerability were all low. The impulsive risk reactive to current personal stressors is still there and things could easily go wrong.

The A&E doctor has carried out a through and searching assessment. They have concluded that there are no signs of mental illness as it would be identified by ICD or DSM criteria, and that risks of self-harm, suicide, harm to others, self-neglect and vulnerability are all low. Nevertheless, the incident in question was dramatic, and underlying relational conflict appears to be ongoing. The A&E doctor is unwilling

[6] Euthymic, neither unduly unhappy (depressed) or unduly elated (hypomanic).

to simply discharge Mr E lest something go wrong. They are threatened by the prospect of being held responsible and so that responsibility is transferred to mental health services, not because there is an 'illness to treat', but because a dramatic series of events has unfolded, and with it the potential for misadventure.

Another example might be:

> Thank you for seeing this man (Mr F) for anxiety management. He attended with his partner of three years. Over the last year he has tended to have outbursts of anger and lashing out, hitting his partner. The most recent episode was five days ago, giving her a black eye. He said this was due to frustration of not getting his money owing to problems with the bank.
>
> He is requesting help and I should be very grateful if you would see him for further management.
>
> PS. His partner popped back into surgery to inform me that he is taking cannabis.

A referral such as this is likely to be judged 'inappropriate' by the multidisciplinary team, and returned to the practitioner. Clearly, there are difficulties, but the angry outburst in question seems to have a comprehensible cause. Once again, there do not appear to be any features of any of the 'illnesses' defined by the ICD and DSM. Furthermore, the account of Mr F's request for help and his partner's return with information about his drug habits suggest that the request for help may well have been an attempt to placate her, rather than genuine interest in change on his part. Short letters such as this encourage such 'reading between the lines' for speculative explanations not provided by the referring agent, and often result in requests for further information that are not answered because the precipitating consultation was impulsive and the crisis has passed.

Violence is an understandable cause for concern, and not infrequently other agencies and the perpetrator might conspire with the attractive view that it is owing to difficulties a professional might be able to fix rather than something that might otherwise be considered by a court of law:

> I would very much appreciate your assessment of this 22-year-old man, who has come to see me today with feelings of loss of control and problems with anger management. He is currently on probation and wearing a tag for offences of assault. He says that last

weekend he snapped and attacked two people; his probation officer is aware of this. He describes lashing out at anyone who confronts him, and cannot control his actions. He says that he has felt like this quite frequently in the past but this has been much worse over the last few months. He describes feeling constantly on edge and very fidgety, like he can't sit still for more than a few seconds. He says that since school he always felt like this, very restless, and has always found it difficult to concentrate on things for more than a few minutes. He also says that he loses his temper easily. He denies there being anything recently that has triggered this worsening in how he feels.

Following the incident at the weekend where he felt very on edge and assaulted two people he says he has feels he cannot relax and has been taking amphetamines and cannabis, and feels this has helped. He denies using drugs on a regular basis but says he has used things in the past; he also denies drinking regularly. At the time that I saw him he said that he had not had anything since the previous day.

When I saw him in the surgery he was talking very rapidly, and it was very difficult to interrupt his trail of speech, which was coherent. He was extremely fidgety during the consultation and did not sit still, getting up and walking round the room constantly. He was making eye contact and his appearance was appropriate.

Following a long discussion with Mr G he strongly felt that drugs and alcohol were not a problem, and he said that it has only been the last few days that he has used these. He is concerned that he has a mental health problem and is very keen to get some help. He tells me that he has taken an anger management course in the past, which he did not feel was particularly helpful.

I would be very grateful for your assessment as to whether there is any further input that would benefit him.

The description of restlessness, feeling on edge and fidgety all the time, against an acknowledged background of amphetamine use, makes it difficult to rule out drug use as an ongoing problem, but Mr G is insistent that 'drugs and alcohol are not a problem', and that 'he is concerned that he has a mental health problem and is very keen to get some help'. Mr G is clearly in trouble, and may well be desperately casting around for help and mitigation. He knows that if he were to acknowledge the part drug use is contributing to his difficulties, then that cause would be lost. The GP is conspiring with this, even though the outcome is likely

to be further anger and frustration on Mr G's part when someone else arrives at the inevitable conclusion.

The Consequences of Alcohol and/or Drug Misuse

Harmful alcohol use and/or illicit drug use are common sources of distress, social disruption and remorse. Even though services specifically designed to provide for those with such difficulties are widely available, these are frequently associated with problems that do not necessarily just go away when the drug taking stops. Furthermore, the complex interactions between psychological distress, drug or alcohol misuse, and social problems mean that many afflicted in this way fall between institutional stools:

> Many thanks for seeing this 32-year-old man, who approached me asking for help. Mr H told me that he felt he was in a crisis. He had been injecting heroin since the age of 16 and had recently finished a methadone programme completely successfully.[7] He is now clean and is not taking any methadone. He says he was having trouble with mood and depression; he tells me that life has not been kind to him. He has taken to drinking alcohol for quite some time to take away the body pain that he suffers and it also helps him sleep. He told me in the clinic that he was not drunk and that he had only drunk one bottle of cider on that day; however, he smelled strongly of alcohol and his speech was slurred. I lectured him about that and he told me it was because of how low he felt, not because he was drunk.
>
> His explanations sound very rational. He told me he was not suicidal, he is currently living with his partner and is having some trouble with arguments with her; she is under the care of (mental health centre). Mr H has a son who lives in (coastal resort) with his ex-partner; he saw him last month for the first time in two years as he had moved back to (nearby small town) from (coastal resort) after he split up with his ex-partner. Because of the argument with his current partner in front of his son he had to send his son back to (coastal resort). He is torn between asking for help and sticking up for his partner, and leaving for (coastal resort) to be closer to his

[7] Methadone is a prescribed opiate commonly used in the UK to support withdrawal and recovery from heroin and other forms of opiate dependency.

> son. I have explained to him that I am unable to supply counselling because of his alcohol dependence and that I would have to refer him to the dual diagnosis team.[8] He appeared to be quite low in mood, yet rational in his conversation with me. I would be grateful if you could help him for further management.

In this case it feels as though it is the GP who is grasping at straws. The primary problem, of heroin addiction, has been resolved but Mr H is in difficulties over the relationship with his son and is drinking heavily. The GP appears to be passing on his desperation to mental health services. Heavy alcohol use and relationship difficulties are a sufficient explanation for the low mood and sleep problems he is describing, but desperation seems to have driven Mr H to the doctor and the doctor, having no other option, has passed the problem on. If narrowly defined as an agency treating 'mental illness', then mental health services will have no more to offer than the GP, however tragic the situation.

Drug and alcohol misuse can also intensify other feelings, leading to the view that otherwise everyday problems might be signs of mental illness:

> Thank you for seeing this 27-year-old man, who is having problems with his temper and also with jealousy. When I first saw him he was drinking quite heavily—20 cans plus some vodka on Saturdays, and around six cans a night in the week. It is about two months since I first saw him and he has cut down his alcohol to two cans a week, but is still getting angry. The second time I saw Mr I he came with his partner, who he has been with for 10 years. She reported that things are getting smashed up or punched in the house. These outbursts can be triggered by quite small things: the most recent one happened because his girlfriend had been out with a friend when he was at home on his own. At times he gets what he calls paranoia when he suspects his girlfriend of being unfaithful. During these times he is convinced she is unfaithful but when I saw him in surgery he thought this was not the case. He telephones other people so that they can check up on his girlfriend, and they feel his behaviour is odd.

[8] A dual diagnosis team is a community mental health team specifically providing for those with both substance misuse and mental health problems.

> He has smoked cannabis in the past, which affected his ideas and made him paranoid. He then changed to drinking alcohol. Unfortunately, two of his close friends are big drinkers. He has been feeling down in the dumps because he was made redundant from his job (skilled labourer) and tried working for himself but that was not successful. Mr I is currently training to be a security guard and is hoping to get a job at (local general hospital).
>
> I would be grateful if you could see him and give him some help.

Again, it is perfectly clear that this is a tragic set of circumstances, and that this man and his partner are at loggerheads. He might possibly fulfil diagnostic criteria for delusional disorder but his suspicions about his girlfriend's infidelity are intermittent and only part of the complex mixture of difficulties he is facing. It is more likely that he is seeking help because he wants a job. What underlying mental illness specialised mental health services are being asked to treat is unclear. It is hard to see why alcohol misuse isn't a full and sufficient explanation for the difficulties Mr I is facing.

Habitual Occupancy of the Sick Role

A significant number of individuals conduct a life that might not be considered ideal by everyone, and that includes some occupancy of the sick role.[9] Characteristically, they will have developed a view of themselves as one suffering a chronic illness, which is responsible for a moderate degree of disability, is not expected to fully resolve and which requires continuing healthcare provision. Many of these are people who have identified their illness as a persistent mental health problem and are likely to have developed a *modus vivendi* in which they experience themselves as permanently disabled. Related healthcare needs and confirmation of this status are usually provided in primary care,[10] and this may well include continuing psychotropic medication.[11] Such cases often involve a difficult and delicate balance in which both parties (GP and patient) conspire to accept the imperfections of the situation in

[9] See note 12, Chapter 2.

[10] Investigations of referral practices in the UK, in this field, have revealed that only 25% individuals considered to have a 'mental health difficulty' are referred on from primary to secondary care services, the remainder making up some 25% of all primary care consultations (Goldberg and Huxley, 1992).

[11] In 2013 NHS practitioners issued in excess of 50 million prescriptions for antidepressants. For reasons above, the majority of these will have been to people seen exclusively in primary care.

favour of a more threatening and unwelcome alternative. Sometimes this difficult and the delicate balance is disturbed by external pressures and the result is referral to mental health services for specialised treatment because reluctance to leave the sick role has been construed 'illness'. Under these circumstances referral can be experienced as unwelcome. It threatens additional stigma and it could suggest a need to change and work towards recovery:

> I would be grateful if you could see this man regarding possible cognitive behaviour therapy. He has a history of low mood which he has reported for many years. He does not feel that his mood has deteriorated in any way. Mr J reports anhedonia.[12] He cannot remember the last time he enjoyed himself. He has no thoughts of suicidal ideation, although he does report self-harming (he hits his head against the wall). He generally eats one meal a day and his sleep is poor.
>
> When I saw him on (date) he was requesting a sick note. He was previously referred to (mental health team), and I enclose correspondence from them.
>
> Mr J has been very reluctant to engage in any mental health services and was absolutely adamant that he would not take any antidepressants. He says he has had these in the past and they have made his symptoms worse. His main priority during the consultation was to get a sick note. I have informed him to have ongoing sick notes for depression he really needs to engage with mental health services and he needs to comply with this.

Needless to say, it is highly unlikely Mr J will keep any appointment offered by mental health services, and if he were to, it would be for reasons other than getting treatment that might make him better. Here the referral has been precipitated by some change in his medical arrangements, possibly a change in GP from one who was happier to accept the imperfections of Mr J's circumstances.

Psychiatric referral letters often describe a complex mixture of what might be considered lifestyle choices, and the sick role that has been perturbed by other external influences:

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[12] Anhedonia, difficulty experiencing pleasure or satisfaction.

> Please would you see this 34-year-old man. Mr K is suffering from anxiety and does not go out very much. He says that people in general make him feel paranoid and thinks they are looking at him.
>
> He has been like this all his life and he assaulted people at school, but not since. He was anxious last week when he was filling out a form for a job application. He did not complete it. He has tried (an antidepressant and a beta-blocker[13]), which do not help him very much. He says that he has had a small amount of counselling before, which he says did not help. He is smoking ~£40 [$65, €50] of cannabis a week, and he would smoke more if he had more money. He is currently being signed off sick but he was a carpenter a few years ago.
>
> I would greatly appreciate it if he could be assessed possibly by a psychiatrist as this patient seems to have got into a rut and he admits that he does not want to be on long-term sick as he says he does not do very well on a low income.

On the face of it, Mr K has lived a life coloured by his condition for some 20 years. He has worked in the past but has received sickness allowances for a number of years. He has tried psychiatric drug treatments. Improvement in his condition is unlikely to be helped by heavy cannabis consumption. The introduction of new regulations concerning sickness payments may well have precipitated the referral, without which he seems likely to have been happy to carry on not working, claiming benefits and smoking cannabis. Mental health services are being invited to get involved because this arrangement has been undermined. On the face of it, it is difficult to see what might be done to alter the situation using conventionally available services.

Sometimes it is a move or other changes that have upset a fragile equilibrium and, quite possibly, added to the difficulties someone is confronting:

> I would appreciate it if this 38-year-old woman could be seen in your clinic. Ms L is newly registered with us; she has a history of depression and has been under (mental health unit) services on and off for a few years. According to the patient she was an inpatient at (mental health unit) for almost 11 days, nine years ago. There is a history of

[13] Beta-blocker, a form of prescribed medication generally used to treat high blood pressure and palpitations but occasionally used in an attempt to mitigate anxiety.

self-harm (three years ago following the birth of her child). She had been on (antidepressant) until 18 months ago when it was stopped by the patient, basically as she was well in herself. However, over the last 3–4 months things have been progressively getting worse with reference to her depression symptoms. There is a history of self-neglect in the current situation. She has moved to (local small town) from (neighbouring local small town); hence, she is a new patient with us (I have not received the full details of her past medical history).

She lives with her partner and four children aged (two in early teens, two preschool age). I have started her on (different antidepressant) and have involved social services and health visitors in reference to the children.

We would appreciate a soon appointment for an assessment for this woman.

Quite a lot has been left unsaid here and, perhaps for reasons of imperfect bureaucracy (not received details of past medical history), could not be said. Why has she moved? What support and assistance was Ms L enjoying before she moved? How are the six of them managing? Ideally, this should be approached as a joint enterprise involving childcare social services, health visitors and mental health services, but the GP has felt obliged to approach it from an 'illness to treat' perspective. Mental health services are being invited to embrace a complex set of social issues.

Sometimes the referral letter hints at the GP's desperation:

I would be most grateful if you would be kind enough to review this 28-year-old woman, who had been battling with depression for a number of years when I first met her back in (five years ago). Ms M has a difficult social situation from a financial viewpoint. She is in a happy relationship with her partner and has three children, two of whom are at school. There are many social reasons for her low mood and we did stop her (antidepressant) for a number of months as she didn't feel it was improving things; however, her agoraphobia and feelings of anxiety are significantly worse on doing so. Ms M also finds it very difficult to put things into words and actually wrote a letter in the middle of (six months before date of the letter), expressing how she was feeling, expressing the impact of her anxiety and agoraphobia, and the effect that is has on her children; she is desperate for help.

At this point, I contacted various agencies, and (organisation to support families with small children) felt that they would be able

> to help and very kindly visited her at home. Unfortunately, there hasn't been a significant improvement following this and, as I say, her anxiety and depression has spiralled. She attended the surgery today desperate for help. She had no active suicidal ideation or feelings to deliberately self-harm, as she wouldn't do that to the children. I have commenced her on (different antidepressant) today with the hope that it will improve her symptoms, but, in view of the severity and duration, I would be most grateful for your input and expertise.
>
> If at all possible I wondered if the initial assessment could be carried out at home in view of her agoraphobia and anxiety, but appreciate that this may not be possible. However, if this was the case it may increase the likelihood of her engaging.

The term 'agoraphobia' immediately suggests the possibility of recurrent panic attacks, and behaviour-avoiding situations where they are threatened … in this case the stereotypical housebound housewife. The GP has been calling this 'depression' for several years and has been engaged in trying to help her but almost exclusively by giving antidepressants. Fear of suffering a panic attack can be so intense that the afflicted will go to inordinate lengths to avoid threatening situations, and not uncommonly develop considerable skill in persuading others to conspire with this. Established treatment is to support and enable the patient to confront their fears and learn that they are groundless.[14] In this case, the GP has been drawn into the conspiracy to avoid that approach. Furthermore, the stereotypical 'housebound housewife' is commonly looking after young children, as is the case here. Children grow and their needs change, and another form of fragile equilibrium can become disturbed by shifts in the nature of domestic responsibilities. Practitioners considering this might be interested in the children's ages and ways in which the changing demands of their activities and other expectations are challenging their mother's limited ability to get out and about. Left unperturbed by her children's changing needs Ms M might well have continued with the GP's affirmation of her disability and sick role, as she has been for so long. It is not the agoraphobia itself that has resulted in referral, but the fact that it is now causing problems in Ms M's life.

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[14] See discussion of cognitive behaviour therapy in Chapter 5.

Finally, it is not only women who are afflicted in this way:

> Thank you for seeing this pleasant 28-year-old man who has a 10-year history of depression. He also suffers with longstanding anxiety, agoraphobia and obsessive–compulsive disorder (OCD).
>
> Mr N is having ongoing issues with his OCD, mainly focused around hoarding. These symptoms started when he was kidnapped at the age of (late teens) and was traumatised by the police response when he was rescued. His OCD prior to this event was different, when he was obsessed with cleanliness. His life is very disordered presently, and he is having difficulty with managing his OCD symptoms. He has a history of cannabis use in the past.
>
> On examination, he has good rapport and eye contact. He was rather jovial in the consultation, and has good insight into his conditions. He was a bit unkempt. He is currently taking (prescribed medication) for vitamin D deficiency, most likely related to his agoraphobia and consequent lack of sunlight. Owing to adverse reactions, he is not currently taking any antidepressants. Any help or advice you could give regarding this patient would be greatly appreciated.

We don't know why Mr N has been referred at this point in time, but it seems likely something has changed, as he is reported to have been housebound for a number of years, long enough for him to be considered suffering from a vitamin D deficiency due to lack of sunlight.

Both of these are longstanding and, as a result, unlikely to resolve readily. In Ms M.'s case it would seem that the difficulties can be understood as consequences of recurrent panic attacks, which might have responded to cognitive behaviour therapy quite readily if addressed when they began. It is unfortunate that did not happen. In Mr N.'s case it is less easy to see how the difficulties might have been usefully addressed earlier, and it is not clear from the letter whether they were known to the GP before now. Nevertheless, he had been left, effectively, to live what must be to many a highly unsatisfactory way of life during his early adult years. A different outcome might well have resulted had he been provided for more energetically after the kidnapping. Instead, he was left to inhabit the resulting disability because, quite probably, he was unwilling to initiate change. To what extent should this be considered a legitimate but unwise choice on Mr N's part, or unsatisfactory practice on the part of previous GPs?

Repeated Anxiety-provoking Behaviour

Another commonly encountered reason for referral to mental health services is a further episode in the life of someone with longstanding problems, which, every now and then, result in distressing or disruptive developments, and who may have attracted the label 'personality disorder':

> Long history of anxiety and depression, despite (antidepressant 1) and full dose of (antidepressant 2), depression not controlled, little pleasure and interest in doing things, depressed and hopeless, problem with concentrating, remains fidgety and restless. Has been under psychiatry until (two years ago) and no further correspondence since then.
>
> Re-referred to psychiatry, and uncontrolled depression; needs further specialist evaluation.
>
> Three years earlier: 'Borderline personality disorder diagnosed in mental health. Miss O has history of multiple overdose, drug and alcohol abuse with suicidal ideation'. 'History of amphetamine misuse', 'Insomnia', 'Suicidal', 'Deliberate overdose of drug or pharmaceutical preparation', 'subject of multiagency risk-assessment conference concerning high-risk domestic abuse families'. Two years earlier: 'Deliberate overdose of drug or pharmaceutical preparation' (three times), 'Recurrent depression'. Assessed on behalf of the mental health team. Miss O is well known to mental health services having a diagnosis of personality disorder. She has been referred to the personality disorder service but so far appears to have not engaged.
>
> One year earlier: 'Deliberate overdose of drug or pharmaceutical preparation' (eight times), 'Alcohol dependence syndrome', 'Chronic alcoholism', 'Cutting self' (twice), 'Arson', 'Arrested in police custody with intent of endangering life'.

Strikingly, there is no explicit reason for the referral other than that Miss. O continues to experience 'depression' and remains restless despite two courses of antidepressant. There are no clear answers to the question 'Why is this person being referred now?' She does have a significant record as one with personality difficulties and previous contact with mental health services. These include self-harm, drug misuse and contact with the police, and it would seem that this legacy itself is the reason for referral. Which of these, in what way, have precipitated the referral is not made clear.

Another example is:

I would be grateful if you could see Ms P soon. She is depressed and is on (antidepressant), and is so low that she has started drinking alcohol in excess and has self-harmed.

She is due to be seen in the clinic for psycho-sexual counselling.

She has a history of overdosing in the past and was seeing a counsellor when she lived (elsewhere).

On examination she is depressed and needs your help.

This brief letter was received alongside another from a mental health nurse who had also been involved:

Ms P has had several contacts with mental health services in the past week, which have been a source of significant stress to herself and others. Her difficulties started approximately a month ago when she severed ties with a same-sex partner, which seemingly cascaded causing her to behave in a destructive, maladaptive manner.

Ms P has drunk heavily for several years but increased her intake at this time and, as a consequence, her 3-year-old daughter has been placed in temporary foster care. She has also started a relationship with the manager from her previous job, from which she has recently been dismissed from having had allegations made about her inability to care for persons in the setting in which she works.

Ms P has harmed herself frequently over this period and has numerous fairly superficial lacerations to both arms, and has also purposely smashed up her accommodation, which ultimately culminated in a detention under Section 136 of the Mental Health Act.[15]

Ms P describes a difficult childhood and was sexually active from the age of 9 years, at the instigation of her parents. She recalls her biological father, who worked as a long-distance lorry driver 'pimping her out' to other drivers at the age of 11 years. Notably, she has had several sexual partners since the age of 15, and alludes to a high level of promiscuity, going from one partnership to another.

She has harmed herself for several years now and generally does so as she finds it difficult to verbally articulate her emotions. She is prescribed (antidepressant) but, unsurprisingly, this has very little therapeutic effect owing to her current intake of alcohol, which is usually between one and two bottles of wine per night.

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[15] Section 136 of the Mental Health Act, 1983. Police powers to arrest someone behaving in a public place in a way that suggests mental health problems, and convey them to a place of safety where more formal psychiatric assessment can be carried out.

> Ms P's difficulties appear to be longstanding and psychological in origin. She does not display any symptoms indicative of an acute episode of depression.

In this case the referral does appear to have been precipitated by consequences of a particular event, breakup of a relationship, but the GP's letter goes into relatively little detail. The additional letter justifies contact by mental health services, not on the basis of what is happening now, but on the basis of a longer litany of problems, which portray a troubled and troubling young woman.

One of the things that is striking about these two cases is the GP's reference to depression and treatment with antidepressant medication. In the first case (Miss O), two antidepressants are being prescribed concurrently against the background of longstanding and complex difficulties. In the second (Ms P), the GP's account is one of unsuccessful medical treatment of her depression, but the referrals meeting is offered a second account of longstanding difficulties and an understanding of their origins. In both instances the referral appears to have been precipitated by concerns over the recent development of risky behaviour unsurprisingly uncontained by medical treatment. In both of these cases practitioners have turned to mental health services and in doing so raised the stakes in relation to their patients and their difficulties, not because there is suddenly new evidence of a 'mental illness' itself meriting specialist input, but because difficulties attributable to longstanding problems have crossed a particular threshold of tolerance.

Disturbed or Disturbing Reactions to Other Healthcare Problems

Finally there are cases in which the primary concern is not a mental health difficulty but a physical health problem. However, the patient's reaction or adjustment to their illness has not followed a smooth or usual path, and related distress has prompted a call for assistance from mental health services:

> Could you please see Mrs Q urgently? She was diagnosed with breast cancer last year and has had quite a roller coaster of experiences since then. Right from the start she made it clear to me that she would never want a mastectomy. Unfortunately, after two local excisions, it has come to this. She feels that she has made the

> wrong decision about this and was pressurised by the family and her consultant.
>
> Last weekend she looked at her chest for the first time because she had the impression that the breast nurse would make her look on the Monday and she would rather do it by herself. Since she has had a look she is even more distressed. Her body image has always been very important for her. Going out looking good with makeup was her coping mechanism to face the world. She does not want to be the person she is now. She feels like she is living in hell. Work keeps her going at the moment. She can speak with people about it there.
>
> Her family are not accepting her in a noncoping role. They don't know how to deal with it. It is quite a complicated situation; her ex-partner is still living in the house and is drinking a lot of alcohol. Her new partner is not dealing with the situation with her breast cancer too well either.
>
> I really think Mrs Q needs very urgent attention from a psychologist to try and learn to accept her new body and I hope that you can see her soon.

The proposition, that a psychologist can provide very urgent attention, offers a clue to the GP's thinking. This is a healthcare matter, and the GP is quite properly involved in supporting Mrs Q. The situation has become more disturbed and distressing than the GP can accommodate, either in terms of the time or the emotional resources they have available, and they have called for help. Crisis management could be helpful, but 'very urgent attention from a psychologist to try and learn to accept her new body' as if a psychologist (or any other form of mental health practitioner) has skills of persuasion denied to others, is, or course, fanciful. The GP's sense of being at the limits of what routine medical practice can achieve is clear.

Sometimes the very nature of a physical health problem results in a situation where distress is considerable and emotional demands are overwhelming:

> I would be grateful for your help with Mr R, who returned from abroad (six months ago) having sustained brain anoxia due to two cardiac arrests.[16] He was left with severe dysarthria and mobility

[16] Anoxia, starved of essential oxygen.

problems due to abnormal choreiform movements of his limbs.[17] He was initially looked after by his mother but it became clear that this could not continue as a long-term arrangement. As a result, he was assessed as an inpatient by (a physical medicine rehabilitation consultant) and was subsequently discharged to the community with a full care package in place. Unfortunately, on the day of his discharge to the community his mother was admitted to the intensive care unit. In addition, it has become clear that Mr R's wife has decided to remain where they were abroad to continue with 'her life', as he puts it. He says this is what he would have wanted her to do but I think that the realisation that his disability is not showing signs of getting better is now emotionally very difficult for him. His carers were concerned a few weeks ago because he was expressing some suicidal thoughts, but these seem to have subsided.

He is on (an antidepressant) and, following my visit today, I suggested that we should increase this to a higher dose.

His comprehension is excellent but he has great difficulty articulating any form of speech. He communicates by means of an electronic alphabet word machine and it is difficult for him to press the keys because of the abnormal movements in his upper limbs. Both he and his carers have asked whether or not counselling might help him and I said I would enquire to see if there was any specialist service that might be available to help with his complex emotional needs, taking into account the communication difficulties he has.

Mr R is clearly in a very difficult situation, but, tragic though that is, it is equally clear why. He deserves a great deal of support and assistance but it is hard to interpret his 'complex emotional needs' as anything other than understandable reactions to what has happened to him. Unfortunately, the demands these are making upon others have led to a search for further support. Mental health services are perceived as the place to go, even though adding 'mental illness' to his list of conditions will not, in itself, lead to amelioration of them. What would probably benefit him best is consistent, reliable practical support with communication difficulties and his other problems while he comes to terms with all the challenges life has suddenly thrown at him.

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[17] Dysarthria, difficulty speaking clearly, usually due to brain damage such as a stroke, or, in this case, a period of anoxia. Choreiform, abnormal, involuntary, writhing movements of limbs or, less commonly, other parts of the body.

Not uncommonly, difficulties such as this are compounded by ways in which an individual's difficulties have to be categorised as *either* psychiatric *or* physical because that is how services are administered:

> Thanks for seeing this 18-year-old female. Miss S presents with quite a lot of problems; from a psychiatric point of view she is getting anxious and panicky, and one of my partners gave her some (antidepressant), which made her feel positively suicidal. A short overdose (four weeks ago) resulted in a brief admission to (local general hospital) and she really felt she couldn't cope at all. Unfortunately, she wasn't referred into the psychiatric services at that time, and although she has been seen by the community psychiatric nurses, they would want her referred back into the system.
>
> Miss S has been back to see me with various other aches and pains but she is constantly worrying and checking things, and this mainly is around her partner, who is a past drug abuser, although he seems clean and the relationship seems fairly stable. She can't really go anywhere without him and therefore she feels very anxious when she leaves the house, and she can't really leave the house and do other things on her own either. Present medication is (beta-blocker), only to try to help her anxiety state.
>
> Under normal circumstances we might just refer her in for anxiety management or counselling, but I think the situation has changed quite quickly and I am reluctant to leave her on the waiting list. The other problems are related to her past medical history.
>
> Miss S was born in (neighbouring county) and had and was diagnosed with (a congenital neurological defect that can be contained with neurosurgical assistance). From the neurosurgical point of view I don't really think there are any problems but clearly this means she has potential issues that may affect her higher functions. In her earlier years she was under the child and adolescent mental health services in (county where she was born) but, of course, she has not only moved, but she is now an adult so she falls outside the specialist support that that service had to offer and now she is here there appears to be no other support for girls of this age.
>
> I am very reluctant to prescribe a further (antidepressant) for her at present until we have at least had a chance to do some sort of further assessment. Given the complex nature of this I would much rather start with a psychiatrist and move sideways, rather than a counselling service and try to move slowly upwards, as I think there is a risk of things deteriorating if we do it that way. Thanks for your thoughts.

Clearly, this is a complex mix of problems that doesn't fit easily into any one set of medical definitions. Miss S is the victim of a congenital abnormality of brain development, which may well have impaired her intellectual development. She has had neurosurgery and although it isn't causing any difficulties at present, she does have an implanted device requires periodic checks and may need more detailed attention in the future. Although only 18 years of age, she has moved away from her family and is in a dependent relationship. She may be suffering repeated panic attacks. The background of a congenital neurological disorder will veer mental health services towards ascribing her difficulties to intellectual impairment. Her emotional difficulties and social circumstances will veer learning difficulty and neurosurgical services towards attributing them to psychiatric problems. Miss S herself is in danger of falling between services administered to provide for one or another set of diagnoses rather than the person they represent.

To Summarise

For reasons of anonymity these 'referral letters' cannot be verbatim but they are based upon actual cases and reproduced in forms that maintain the style of the originals. Furthermore, they have been constructed against the background of considerable experience in contributing to weekly multidisciplinary meetings at each of which some 20–30 such letters would be read aloud and considered, and numerous clinical encounters with the patients such letters refer to. Their classification into six groupings is for illustrative purposes. It does not reflect systematic research but it does add to published research (see Shaw et al., 2005), which more formally demonstrates how such referrals are made on the basis not of a likely or possible DSM or ICD diagnosis, but of the disruption and distress the presenting problems are causing. All give insights into tragic and difficult circumstances. Insofar as they are representative these examples demonstrate that in the context of a public health service, at least, it is social disruption rather than clear diagnostic criteria that prompts referral to mental health services. It is the discomfort and threat caused by distressed or disturbed people that prompts a call for assistance from psychiatry. In many of the cases the GP will have been attempting to address the problem themselves by prescribing an antidepressant and offering support and counselling. Critical developments prompting a referral to mental health services and all that flows from it are not the presence of symptoms that might suggest mental disorder. Referral is prompted by a level of social disruption

and distress deemed intolerable or uncontainable in any other way. It can take a variety of forms: concerns for children's safety, self-harm, violence, personal distress or threats to others. Sometimes it is clear or highly probable that the difficulty reflects law breaking but when it doesn't, and sometimes even when it does, mental health services are approached in pursuit of a solution. In the context of the UK NHS it is easy to fall into a trap of criticising GPs for passing on this part of a collective burden of work and responsibility just because the situation has become too pressing, but to do this misses an important point. However medically dressed up mental health services and the terminology they use might be, the inescapable consensus is that they are there primarily to respond when other attempts to contain disturbing, distressing or anxiety-provoking behaviour are proving unsuccessful. That is their job. Psychiatry is what happens when all other attempts to prop up someone's social world have failed. Circular philosophic musings have difficulty defining mental illness. Attempts to force the square peg of psychiatry into the round hole of medicine have their limitations. On the ground what psychiatry actually does is to respond to expressions of a need to do something about disturbing or distressing disruptions of social order that are not accommodated in other ways. These may turn out to be associated with particular patterns of behaviour such as heard voices, panic attacks or misery, but it is the disruption of social order that brings the person to psychiatric patient-hood, rather than the other way round.

7
All in the Mind

Suspending belief in a medical approach to mental health difficulties and viewing them primarily as disturbances of social order takes one into territory that is unfamiliar to most who are grounded in the medical approach. Conventions identifying psychiatry with the rest of medicine make it difficult to think of as essentially a response to disturbances of social existence, even if that is what frontline experiences suggest. The logic of medicine is very much that of the engineer who interprets whatever might be the difficulty—a smoky car exhaust, unreliable electrical power, wet or dampness in the wrong place—as evidence of a material problem. They draw attention to the engine, the power line or the roof in pursuit of a fault that can provide a sufficient explanation for the problem, in terms of what happens when engines, power lines or roofs don't operate as intended. This is the process of diagnosis through which a difficulty or inconvenience is translated into the consequences of a clearly defined dysfunction, in medical terms a pathology resulting from a disease. Chapters 2 and 4 discussed how and why that may not be the best way to consider mental health difficulties and their treatment. Mental health difficulties are poorly served by the application of a mechanistic logic because they cannot be sufficiently explained by a generally accepted and agreed understanding of how human beings or their brains actually function, what might be the cause when they don't function satisfactorily and even how medical treatments work when they do.

When it is clear that seeking a material, physical explanation of someone's difficulties is not going to bear fruit, the problem tends to be identified as 'all in the mind'. This can be experienced as derogatory and stigmatising, but it is also a signal that the problem resides in psychiatry's territory, is best understood as something arising from 'mind'

rather than 'body' and is best addressed with the same distinction in view. There is nothing recent or new about this. The notion of 'mind' or 'spirit' as something distinct from 'body' and yet also susceptible to dysfunction and potentially the source of difficulties is an integral part of human history. There is evidence of trepanning from very early human relics, although reasons behind it are probably many and have to remain the subject of speculation.[1] The Ebers Papyrus, an Egyptian medical treatise dating from around 1550 BC, refers to conditions we might recognise as depression. References to marked disturbances of emotion are found in ancient Hindu and Chinese scripts. Hippocrates' writings included a classification of mental health difficulties, and one of Jesus' miracles was the casting out of demons from two 'demoniacs'.[2] The Holy Qur'an also provides a number of references to relationships between spiritual and psychological well-being.

European history includes numerous ways in which 'mad' people have been understood and provided for in more recent centuries. Although these form the background to contemporary first-world practices this is not the place to review them in detail. There are several scholarly and some more popular works that do so from a variety of perspectives (see, e.g., Foucault, 1961; Scull, 1989; Berrios, 1996; Porter, 2002), and there is a consistent theme. In medieval times, behaviour that we might identify as a mental illness was commonly attributed to malign supernatural influence and provided for by priests charged with maintaining religious orthodoxy. During the early Enlightenment and Agrarian Revolution of the seventeenth and eighteenth centuries 'madness' was associated with other expressions of poverty and irresponsibility, and provided for in the form of often punitive regimes in the workhouse or houses of correction. With the coming of the Industrial Revolution in the late eighteenth and nineteenth centuries the 'mad' were amongst those considered degenerate or incapable of conforming to the increasingly regimented expectations of the time, and incarcerated in the asylum. For the more privileged 'madness' meant a sequestered and often abused life at home or in a madhouse, in order to shield the family from burden and associated shame.[3] In other words,

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[1] Trepanning is a surgical intervention whereby a hole is drilled or scraped in the skull to expose the tissues within. Brothwell (1963) considers a number of possible reasons why primitive surgeons might have done this but altering the subject's state of mind is a likely contender.

[2] Gospel according to St. Matthew 8:28–34.

[3] Cf. Mrs. Rochester in *Jane Eyre* by Charlotte Brontë, published in 1847.

throughout recent European history and that of its colonial derivatives, mental health difficulties have been identified with disruptions of social conformity or social order, and understood as disturbances of spiritual, mental or moral, rather than bodily function. The person who is a source of concern to others for reasons other than criminality or bodily illness has been a distinct part of the human landscape for as long as there has been one, and that continues into the present. Popular discourse, folk knowledge, media portrayals and everyday experience all concur that when a person behaves in ways that others find disturbing and that cannot be censured as unlawful or attributed to physical brain damage or degeneration, the problem is considered to be 'mental' or 'all in the mind', and psychiatry is the place to go for help. As such problems are, by definition, not susceptible to the diagnostic logic of a potentially detectable and sufficient 'bodily' explanation, different logics pertain and other historic and institutionally established conventions compete with medicine's. This chapter continues with an illustration of these differences by considering what has happened as two conditions previously thought to be 'all in the mind' have acquired a 'bodily' explanation and, as a result, have migrated from being viewed as a mental health difficulty to being viewed as a medical one. It then discusses how mental health difficulties might be better conceptualised if they are truly acknowledged to be those best thought of as 'all in the mind' by reference to some pertinent sociological concepts.

For some it might be helpful to first set the scene by reviewing historical distinctions between 'mind' and 'body', and how these might be framed in a contemporary context. What follows is a pragmatic approach to this by way of background to how 'mind' and 'body' approaches differ, and how the former inescapably demands attention to the social world.

Cogito Ergo Sum

Repeated encounter with a mind/body dichotomy is everyday business for most psychiatrists. To outsiders, other healthcare practitioners, service users, their associates and the wider public, psychiatry is exclusively concerned with problems of the mind. A long-running BBC radio programme dedicated to discussing psychiatric topics goes under the name of 'All in the Mind'. However, psychiatrists are primarily medical graduates schooled in an environment of biomedical science, which derives its authority from knowledge about the human body as a material object.[4] For as long as there is an irreconcilable distinction between

[4] This is discussed at greater length in Chapter 2.

mind and body, psychiatrists are challenged to reconcile the irreconcilable. There may be readers who find what follows familiar territory. For others it could fill a niggling gap.

Distinctions between physically identifiable brain activity and mental life are philosophically challenging and increasingly difficult to make at a practical level. Famously, the notion of a distinction between mind and body is identified with René Descartes,[5] to whom is attributed *cogito ergo sum*; 'I think, therefore I am'. The premise is that thinking or 'mind' are predicated upon awareness of that which is being thought about. 'I' or my 'mind' is not my body and, indeed, we commonly speak of 'my body', 'my heart' or even 'my brain'. Descartes was writing in the seventeenth century when the mysteries of human anatomy were only beginning to be unravelled by European anatomists and thinkers. It was difficult to embrace the notion that 'mind' or thinking could be the product of something as mechanical as the human body was beginning to be understood, and that the body could be realised by something ('mind') that did not exist independently of it. Søren Kirkegaard presents a critique of the logic behind this.[6] Nowadays, exhaustive logical or philosophic analyses are barely necessary to identify thinking or 'mind' as something that the body, or at least the brain is equipped to do, but a distinction between mind and body runs deep in our culture. Public reactions to neuroscience reflect these fascinations and confusions. The news headline so often runs 'Brain scanning has shown that when you (do something, are someone), your brain is acting in a particular way'. Even though we have become comfortable with the view that the body incorporates something (the brain) that is capable of the sorts of things we attribute to mind, popular culture and everyday discourse have yet to fully assimilate the implications.

The development of computers has demonstrated that machines can 'think', and our knowledge of the intricacies of the human brain's circuitry now makes it easy to accept that the brain can support the familiar complexities of human thinking. Nevertheless, mind and body are clearly experienced in different ways and as different things. A way

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[5] René Descartes (1596–1650) was a French philosopher, mathematician and writer.

[6] Søren Kirkegaard (1813–55). His criticism takes the form of the following logical steps: *'x' thinks: I am that 'x': Therefore I think: Therefore I am*. This reveals independence of the statements 'I think' and 'I am' as independent qualities of 'x', which both thinks and carries the identity of 'I'. Thus, thinking and being are assumed but not mutually necessary qualities of 'x'. 'x' can think, and 'x' can be 'I', and if 'x' is a body containing a human brain, then that body can both think and be a person without one predicating the other.

forward is to recognise that distinctions between mind and body are not so much distinctions between different *things* but distinctions between different *ways of looking* at the *same* thing. A person waving their hand can be observed by someone else for what that is—a gesture—and the experience might include interpretation of its meaning, such as a greeting, farewell, beckoning or dismissal, depending upon other clues such as facial expression and posture. By the mid-1970s early brain scans were able to demonstrate activity in the brain's motor cortex when a subject spoke, waved their hand or conducted other simple tasks.[7] When waving one's own hand, physical sensations from the hand and arm are likely to be accompanied by relational experiences such as welcome or parting, which will differ depending upon the social context. Behavioural observation, medical science and subjective experience all detect the same thing: a waving hand. How they differ is in the perspective from which they consider it. Mind and body need not be considered separate things but instead distinct ways of looking at the same thing—a person and their activities—from different viewpoints and, where necessary, with the help of different technologies. The hand and arm are moving, certain parts of the brain are activated are bodily perspectives. I am beckoning, greeting or dismissing, they are beckoning, greeting or dismissing are mind perspectives but it is the same event that is being considered, albeit from different points of view.[8]

Psychiatry is essentially a pragmatic enterprise, and that is a theme of this book. Whether a mind approach or a body approach, or even a combination of the two, is most appropriate depends upon how helpful it is going to be. Although brain scans might be able to demonstrate features associated with mental illnesses such as schizophrenia, anxiety or depression, until or unless they reveal more about the causes of these conditions and make practical contributions to how they might be remedied they add little to what is already known and being done. Brain

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[7] Imaging of brain blood flow and thus by proxy underlying brain activity was first achieved by detecting the flow of a small dose of radioactivity injected into and circulating with the blood. The technique is known as positron emission tomography, or PET (Lassen et al., 1978).

[8] The philosophical position which holds that there are multiple ways of viewing the same phenomenon, each of comparable validity and each defined by the perspective and tools employed, is variously known as critical realism or soft constructionist. It has informal origins in allegories such as that of the six blind men going to 'see' an elephant (note 34, Chapter 5). Bhaskar formalised the approach in *A Realistic Theory of Science,* first published in 1975 (Bhaskar, 2008/1975), and it has been further developed by Sayer (1992).

scans might show that the brains of those considered to have schizophrenia, anxiety or depression are different from those of unaffected individuals, but we already know from their behaviour and subjective reports that people considered to have schizophrenia, anxiety or depression are different from others in identifiable ways. Brain scans and other technologies add nothing to this unless they offer something about schizophrenia, anxiety or depression from a bodily perspective that might be truly helpful in understanding, preventing or treating those conditions. Scientific advances in the bodily perspective of some conditions have achieved that, with striking changes in how the conditions are viewed and provided for. Two examples follow. What they illustrate is that when technical advances do provide useful bodily insights into conditions previously considered to be 'all in the mind', they cease to be the business of psychiatry. In other words, although it might be possible to visualise bodily manifestations of certain mental health difficulties in the form of an abnormal brain scan, until technology also provides a genuinely better way of understanding the condition or providing for it they remain best understood and provided for from a mind perspective, and that is what psychiatry is there to do. Should technology offer a truly better approach, then the condition will cease to be best thought of from a mind perspective, and psychiatry would cease to be the chosen discipline. As Chapter 4 considers, the human brain's complexity is such that the likelihood of ethically acceptable, safe and effective technologies becoming available to alleviate most currently psychiatric conditions is vanishingly small, and as Chapters 5 and 6 outline, there is far more yet to be explored and exploited by considering people, their difficulties and responses to them from a mind perspective. However, in recent times at least two conditions have crossed from being viewed primarily from a mind perspective to being viewed largely from a bodily perspective. The outcomes are quite different but together they illustrate how significant changes in perspective upon a condition can come about when that does happen, and what the consequences can be.

The Case of Epilepsy

Until well into the twentieth century epilepsy was considered a form of insanity and provided for in similar ways. Grand mal epileptic fits can be profoundly disturbing to witness, and not uncommonly cause injury and incontinence. Those who are repeatedly subject to them can be ostracised and subject to considerable social distancing. Epilepsy can be caused by a variety of bacterial and parasitic infections such as

meningitis, tuberculosis and schistosomiasis. With the availability of antibiotics it has become much less common in parts of the world not widely subject to tropical diseases. In Europe and America, until well into the twentieth century epilepsy was a common form of acutely disturbed and disturbing behaviour often responsible for quite dramatic events in public places. Those suffering epilepsy were socially disabled and often cared for with the other 'insane'.[9] That tradition continues in many low- and middle-income countries.

Electroencephalography (EEG) developed during the early decades of the twentieth century,[10] and people with epilepsy were first shown to have abnormal electrical brain activity in the 1930s. The sedating effects of barbiturates had been known since the 1900s and they had become widely used as tranquillisers in psychiatric settings, including amongst people with epilepsy, where they proved particularly effective. It was not long before it became clear that treatment with barbiturates and other anticonvulsants had an effect upon the EEG. The conjunction of a clear biological explanation for epileptic fits and a medical treatment that not only worked, but did so in a way that fitted with a bodily understanding of epilepsy, enabled a radical shift in the way epilepsy and those who suffer it are considered. In higher-income countries epilepsy is now widely understood in terms of bodily causes and it is no longer considered a mental illness. It is provided for by neurologists rather than by psychiatrists. Those who suffer are encouraged to regard themselves as no different from anyone else other than the need to take a particular form of medication and, where appropriate, limit the risks of head injury when fitting by wearing protective clothing. In contrast, in those parts of the world that have yet to fully embrace the implications of a sufficient bodily explanation for epilepsy, the condition continues to be considered a mental illness.[11]

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[9] The first 'epileptic colony' in the USA was opened in Ohio in 1893 in order to provide the 'best possible methods of caring for the epileptic and the epileptic insane' (Kissiov et al., 2013, p. 1524).

[10] EEG is the use of electrical instrumentation to obtain and record an amplified representation of the brain's electrical activity. The first human EEG was obtained in 1924 and subsequent decades saw the identification of electrical signals characteristic of epilepsy.

[11] The World Mental Health Gap programme (mhGAP) includes epilepsy amongst the mental health conditions felt to be underprovided for in low- and middle-income countries (World Health Organization, 2011).

The Case of Senile Dementia

Many of the asylum inmates of the nineteenth and early twentieth century eventually succumbed to a condition known as 'general paralysis of the insane' (GPI). This is now known to be a late stage of a brain condition due to chronic syphilitic infection. It often took the form, initially, of an acute psychosis. Over a prolonged period of time memory and muscular coordination would deteriorate, and the victim would eventually become paralysed and die. As the study of infectious diseases gathered pace syphilitic infection and its longer-term consequences became understood for what they are. The disease fell under antibiotic control, and GPI has become very unusual. This progress stimulated a wider search for other forms of brain disease that could explain other forms of progressive mental and behavioural deterioration. Several types of progressive brain degeneration are now recognised,[12] of which Alzheimer's disease is the most common. In parallel, collective understanding and reactions to ageing and increasingly frail and forgetful people has changed. They are no longer viewed as victims of insanity, but instead as victims of biologically identifiable degeneration of the brain. However, in this instance, although biomedical science has provided a sufficient and widely accepted bodily explanation of the disorder, it has yet to provide an effective treatment. In contrast to epilepsy, senile dementia is not generally understood as a condition people can recover from or be treated for. As a result, there are few expectations of full recovery once the condition is established. Its manifestations are very much those of a deteriorating mind. Although this can be and now generally is attributed to a degenerating body, or brain, provision for and care of someone with any form of senile dementia is very much that of accommodating the fact that they are losing their mind. Care of those with dementia is not a treatment that will repair the degenerating brain. Some medicines are credited with slowing the rate of degeneration but care of the afflicted and support for those associated with them are limited to practical support and understanding. In contrast to epilepsy, clarification of a 'bodily' explanation for senile dementia has not, as yet, resulted in an effective bodily treatment, and the perspective of related healthcare is very much that of providing for a psychologically disabled person. Much the same is true for those who have suffered

[12] Others include Pick's disease and Lewy body dementia, which are commonly associated with Parkinson's disease, and Huntington's chorea.

brain injury, serious congenital learning difficulty or other forms of organic mental disorder.

Whether a condition is considered 'all in the mind' or 'a physical illness' is not clear cut, depends upon a complex interaction between formal scientific knowledge and tradition, and can even vary from place to place. When there is a clear biological explanation for the condition and an effective medical treatment to go with it, 'physical illness' is the perspective, and the organisational framework is neurology or another medical specialty. When there is neither, 'all in the mind' is the perspective, and psychiatry is the organisational framework. The grey area in between, occupied by conditions such as senile dementia, brain injury or congenital learning difficulties, where there might be a credible bodily explanation but no effective bodily treatment, is organisationally and conceptually disputed territory. Mainstream psychiatry is concerned with conditions for which there is (as yet, perhaps) no agreed and credible bodily explanation, and therefore no agreed and credible explanation for the effects of bodily treatments, other than in very general terms.[13] This means that from a purely practical point of view psychiatric conditions have to be approached from a mind perspective rather than from a bodily perspective. This is not to say that they have no bodily representation or that images of a bodily representation rule out the value of a mind perspective. What it reflects is nothing more than that there is, as yet, no credible bodily explanation and/or related bodily treatment. Those of differing ideological positions might have different views upon whether or not science will ever provide credible and sufficient bodily explanations for anxiety, depression, mistrust, voice hearing and the many other difficulties that come to the psychiatrist. What is undeniable is that psychiatry is defined by its focus upon the mind perspective. As has happened with epilepsy, should a truly credible, widely accepted and therapeutically effective bodily perspective become available for any one of these or another psychiatric condition, the condition would cease to be psychiatric territory. Nevertheless, whichever ideological position one might take in relation to science's potential to unravel the human brain, providing for those suffering mental health difficulties in the here and now, and supported by knowledge that is currently available, means that there is very little on offer that is not derived from a mind perspective, and, to all intents and purposes, 'mind' is synonymous with 'social'.

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[13] See discussion about psychiatric drug treatments and the 'placebo' effect in Chapter 4.

Functional Impairment

Whether a set of personal difficulties is viewed from a mind or from a bodily perspective has considerable implications for what is seen, or at least what comes into focus. A bodily explanation implies a specific, identifiable cause of the difficulty rooted in dysfunction of potentially identifiable parts of the body, in this context usually the brain. A bodily explanation implies that were the person to die, a post mortem examination would reveal predictable findings such as the neuronal degeneration found in various forms of senile dementia. The person's difficulties can be understood in terms of biological frailty, and focus is upon the consequences of that and how to best accommodate it. This is an expression of the doctrine of specific aetiology, which has an important place in medical thinking and practice.[14]

When there is no credible bodily explanation for the difficulties and a mind perspective is more appropriate focus has to be upon a much wider range of contributing influences. A mind perspective implies contributions to the difficulty from temperament, how that has developed during childhood, the social and material circumstances in which the difficulty has developed, social and material circumstances that may or may not be maintaining it, and how help is being sought, as well as any contributions there may be from putative bodily influences such as inheritable vulnerabilities. Unlike the material focus of a bodily perspective, these are generally too numerous and complex for any one of them to provide a specific aetiology or, in themselves, offer a helpful focus for understanding and treatment. A mind perspective necessarily involves acknowledging these complexities.

Traditionally medicine uses the terms 'organic impairment' and 'functional impairment' to distinguish between consequences of an identifiable bodily dysfunction, and those considered due to other causes. The former refers to difficulties that can be attributed to a bodily cause, and therefore allows focus upon a specific set of difficulties that can be attributed to it. The latter refers to difficulties that cannot

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[14] The expression is attributed to René Dubos (1901–82). It refers to the notion that with sufficient investigation and analysis a medical condition can be attributed to a specific cause. Its influence and popularity derived from the achievements of microbiology, to which Dubos contributed, in providing clear and effective ways of understanding many medical conditions as various forms of reaction to identifiable microorganisms. It is less applicable to many more contemporary medical issues such as arterial disease, but it retains a strong hold on medical thinking and teaching.

be attributed to a known bodily cause, and therefore have to be understood in wider, more holistic terms. A person with senile dementia, brain injury or congenital learning difficulties may have social impairments such as difficulties relating to others in a reliable and congenial way, problems organising their life or disruptive behaviour, but, given the credibility of a bodily explanation, for them these are understood and generally accepted as consequences of the condition. Someone suffering recurrent panic attacks, someone who is profoundly depressed or someone who is hearing voices might well have comparable social impairments. In their case, however, the various putative contributions to the problem such as temperament, background and context, which make up an understanding of 'functional', are unlikely to be dismissed so readily. Instead, they are likely to be incorporated into how the difficulty is understood, bringing with them evaluative judgements about responsibility for the difficulty and the contributions of others' actions. These add their own colours to how it is viewed, and how it should be provided for. As there is no bodily explanation providing a focus of understanding and treatment, a functional impairment is a much more challenging phenomenon than an organic one because of the much wider range of factors that have to be taken into account if full sense is to be made of it.

These factors inevitably include social dimensions of the difficulty; indeed, in many instances, 'functional impairment' actually means 'social impairment'. The presence of a credible bodily explanation for them relegates the social difficulties of someone with a brain injury or dementia to the status of inescapable secondary consequence, however trying and difficult they might be. It is accepted that the person in question is behaving as they are because their brain is physically not what it should be. There may even be scans that depict the loss of brain tissue in places and ways that make sense of the behavioural and social difficulties the person might be suffering. In contrast, a functional impairment, which, by definition, lacks a credible underlying bodily explanation, also lacks an external point of reference. The condition or difficulty is not explicitly due to an independent cause. It is what it is, including its social concomitants. As a result, not only do social difficulties play a prominent part in shaping whether or not someone is identified as suffering a mental illness by dint of their referral to mental health services, but they have also come to play a prominent part in formal measures of severity and treatment outcomes.

Assessments of Function

During the 1970s, when psychiatric research fully embraced enthusiasm for the scientific method, need arose for measures of severity that could be used to compare cases and to evaluate treatment. The Global Assessment Scale was developed and refined (Endicott et al., 1976), with a derivative, the Global Assessment of Functioning (GAF), becoming part of the American Psychiatric Association's (APA) diagnostic and statistical armamentarium until the publication of Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 in 2013. The GAF is a series of ten statements that may or may not apply to the person in question. They vary in terms of the extent to which the person may or may not be a source of concern to others, and range from 'life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities' (scored 100–91) to 'persistent danger of severely hurting self or others (e.g., recurrent violence)' or 'persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death' (scored 10–1). Intermediate items include 'some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships' (scored 70–61) and 'major impairment in several areas, such as work or school, family relations, judgement, thinking, or mood (e.g., depressed man avoids friends, neglect family, and is unable to work, child frequently beats up younger children, is defiant at home, and is failing at school)' (scored 40–31). Use of the scale involves choosing the statement that most closely describes the person in question, and assigning a score between 1 and 100. With the publication of DSM-5 in 2013 the APA replaced the GAF with the World Health Organization Disability Schedule, version 2.0 (WHODAS 2.0; World Health Organization, n.d.), as its preferred scale for rating severity. The 36-item self-administered form of WHODAS asks for a rating of ability in each of seven domains: Understanding and communicating; Getting around; Self-care; Getting along with people; Life activities—Household; Life activities—School/Work; and Participation in society. In order to obtain a score the respondent is asked to answer, for each of between four and eight items for each of the domains, how much difficulty there might have been with activities during the preceding 30 days. Illustrative activities include 'remembering to do important things' and 'generally understanding what people say' (Understanding

and communicating), 'standing up from sitting down' (Getting around), 'staying by yourself for a few days' (Self-care), 'dealing with people you do not know' and 'getting along with people who are close to you' (Getting along with people), 'Taking care of your household responsibilities' (Life activities—Household), 'getting all of the work done that you need to do' (Life activities—School/Work), 'How much of a problem did you have because of barriers or hindrances around you?' and 'How much of a problem did you have in doing things by yourself for relaxation or pleasure?' (Participation in society). A numerical score is derived from respondents answering 'none' (no difficulty), 'mild', 'moderate' or 'severe'. In the cases of both the GAF and WHODAS 2.0, 'function' that may or may not be impaired by a mental health difficulty is clearly identified with the ability to operate satisfactorily in the social domain.

The importance of social impairment as a defining feature of mental health difficulties is also emphasised by the part played by the expression 'level of functioning' in many of the diagnostic criteria making up the DSM. In DSM-5 a diagnosis of Schizophrenia requires, amongst other things, that 'for a significant period of time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset' (American Psychiatric Association, 2013, p. 99). To qualify for a diagnosis of major depressive disorder, in addition to whatever symptoms of depression might be present, such symptoms must also 'cause clinically significant distress or impairment in social, occupational, or other important areas of functioning' (ibid, p. 161); in the case of obsessive–compulsive disorder the requirement is that 'the obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning' (ibid, p. 237), and exactly the same criteria apply for conduct disorder (ibid, p. 470) and many other conditions. Social consequences of a mental health difficulty are not just unfortunate or tragic consequences. They are prominent defining features. Symptoms attributable to a particular 'mental illness', such as sleeplessness, fatigue, voice hearing or irritability may be present, but the situation does not qualify for a 'diagnosis' until or unless the symptoms are accompanied by a significant level of functional disturbance, and 'functional' in this context quite clearly refers to social function: the ability to get on with others without causing them distress. Similarly, severity is measured in terms of how much or how little the person's ability to manage as an autonomous but socially interactive individual is impaired, and the value or

the effectiveness of a treatment is established on the basis of whether or not it can reverse such limitations.

Much might appear to have changed since psychiatry was synonymous with priests casting out devils, or with incarceration in a madhouse, but its core business remains unchanged. Psychiatry is still identified as that part of the human enterprise that deals with disturbances of the mind. Postmodernity can clarify mind/body dilemmas by recognising the mind/body distinction as one of perspective or approach rather than a debate about distinct phenomena. Where medical science can provide a credible and agreed bodily explanation for a particular set of difficulties, and a treatment that addresses it, the condition is not part of psychiatry's remit—impairment is described as organic impairment and directly attributed to the bodily cause. Where medical science cannot provide a credible and agreed bodily explanation for a particular set of difficulties, then the condition is considered to be 'in the mind' and psychiatry has a part to play. Impairment is described as functional impairment, which is a complex set of difficulties best viewed holistically. A holistic approach to personal difficulties emphasises the importance of social capabilities and their disruption. Social capabilities and their disruption are core features of contemporary definitions of mental illness and its severity, and so psychiatry remains defined by its concern for those who are the focus of social disruption, as it has been for centuries. Not only is this reflected in the reasons why people are referred to mental health services, but the extent to which someone is generating social distress is also a primary feature of official diagnostic criteria and of formally applied measures of severity. For these reasons a full understanding of psychiatry is only possible if it includes direct consideration of the social disruptions mental health difficulties represent and why these are so often experienced as pressing and distressing.

Reactions to Distress

Pain, disability, gore and the risk of death, which are the stuff of medicine and surgery all evoke strong reactions in those around the victim but they are quite distinct and different from the reactions evoked by mental health difficulties. Pain, disability, gore and the risk of death are signs of biological frailty, of susceptibility to injury and life-threatening infection or physiological dysfunction. The torment of physical pain, the consequences of a lost limb or blindness, or failing health that threatens death are all distressing to witness but the responses they evoke are generally well defined and directed towards alleviating the problem or limiting suffering. However distressing a physical illness

might be, the situation is accommodated by socially co-locating it with general acceptance of man's biological frailty and physical imperfections, and certain rights and responsibilities follow.[15] In contrast, mental health difficulties are conditions that cannot be identified with biological frailty in the same way. Although exhaustion, injury or even malnutrition might result from a period of disturbed behaviour, it is their emotional and behavioural difficulties that draw attention to those with 'mental illness'. Apart from risks of misadventure or acts of self-destruction, others are not drawn to the mad because they fear they might be dying. There may be vivid evidence of emotional pain, but this evokes a different reaction from that evoked by an encounter with one tormented by physical pain, and disturbing though an emotionally distressed person might be, the reactions they evoke are different from those evoked by an encounter with blood and gore. Initial reactions to the frightened, the confused, the despairing, the threatening or the suspicious reflect the disturbed emotions themselves. One who is evidently frightened might well cause others to try and understand why they are frightened, with a view to providing empathy and reassurance. Confusion usually evokes firm, directive support. Despair is commonly associated with attempts to understand and commiserate, and threatening or suspicious behaviours evoke their own patterns of response. The emotionally distressed engage others in ways that are more complex and differentiated than those evoked by biological distress. Someone who is clearly suffering from a medical condition is likely to evoke reactions in response to signals read as 'I am unwell'. Such reactions might vary in terms of their urgency and readiness to involve professionals, but they are all likely to follow the same basic pattern: 'Rest up and I will do what I can to help you'. Fear, confusion, despair, threat or suspicion are experienced differently and evoke largely distinct reactions. Furthermore, the reactions they evoke are not always charitable and constructive. Consider, for instance, an encounter with someone who is clearly threatening.

Emotional interactions are very powerful forces, and they are frequently very difficult to contain. Charles Darwin described ways in which emotions are expressed by humans and other animals, and the

[15] Rights and responsibilities, the institutionalised pattern of relationships that defines the sick role, and obligations of 'patient' and 'healer' are well established and broadly identified by Talcott Parsons (1951). Together they define a set of arrangements, such as rest and assistance with nourishment, that minimise physiological demand, and oblige others to provide them. Arrangements subsumed under the 'sick role' are a socially endowed platform upon which to conduct activities designed to counteract biological frailty, and they are described in more detail in note 12, Chapter 2.

contributions these communications make to the survival of species and thus to the process of evolution.[16] It is barely surprising, therefore, that they are commonly experienced as hard wired, find expression when and in ways that might not always be helpful and certainly contribute to how we react in the company of those troubled by their own feelings. Rather than evoking the predictable, well-trodden, charitable and widely respected 'Rest up and I will do what I can to help you' reaction to someone clearly identified as suffering a bodily illness, the emotionally disturbed evoke a wider range of reactions and social consequences. These deserve attention in their own right. The effects people have upon one another, distressed or otherwise, are the subject matter of social psychology and social science. Over recent decades these disciplines have had only a limited place in medical and even psychiatric education. Others have outlined the troubled relationship between medicine and the social sciences, and one conclusion is that it reflects political and material conflict as much as it does true intellectual dispute.[17]

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[16] *The Expression of the Emotions in Man and Animals* was first published in 1872 (Darwin 1872/1965). It gives an early, thorough and thoughtful account of ways in which internal states such as anxiety, despair, anger and devotion are communicated by posture, voice and facial expression among several nonhuman species and between people. The work stands alongside Darwin's more widely known treatise concerning evolution as a landmark set of observations which similarly identify the world of the human being with the wider, biological landscape. The 'insane' are included amongst the case studies making up this work.

[17] There is an established longer-term tradition of social sciences research and teaching that has considered mental health difficulties, and has already been referred to in note 39, Chapter 5. It includes Emile Durkheim's reflections upon social isolation and suicide, early (Faris and Dunham, 1939) and more recent epidemiological research seeking the social determinants of schizophrenia and other conditions (Morgan et al., 2008), Erving Goffman's seminal studies of asylum life in the 1960s and Rosenhan's 'On being sane in insane places' (Rosenhan, 1973). During the 1960s explicitly sociological approaches to mental illness, such as Thomas Scheff's *Being Mentally Ill* (1999), enjoyed some influence, and that work has been re-issued more recently; however, during the 1980s and 1990s social sciences' theoretical contributions to the study of mental illness were eclipsed by enthusiasm for identification with biomedicine among academic psychiatrists (Gove, 1982; Roth and Kroll, 1986; Guze, 1992), and the reputation of rather populist but impractical and somewhat prophetic positions that had became known as 'antipsychiatry' (Szasz, 1961; Laing, 1967). Although it is now in a fourth edition and it has won book awards from the British Medical Association, Rogers and Pilgrim's *A Sociology of Mental Health and Illness* (2010) has yet to be broadly welcomed into psychiatric training, and sources of medical research funding are reluctant to support the more constructivist or interpretive methodologies social sciences tend to favour.

Psychiatry's core business of concern with social phenomena, such as emotional interactions, relationships, the consequences of developmental experiences and the availability or otherwise of social support, means that its work cannot be conducted or its research advanced without attention to social dimensions. Any attempt to define or describe what psychiatry is or does would be incomplete and insufficient without reference to the social world and how it is understood by those who study it. Social science offers four conceptual frameworks that make particularly valuable contributions to how psychiatry can be better understood and practised. They are the concepts of 'social order', 'social deviance' and, more specifically from medical sociology, 'help seeking and medicalisation'.

Social Order

As illustrated in Chapter 6, patients are commonly referred to mental health services because they are disturbing others to an unwarranted degree or in a particularly disturbing way. The history of 'madness' is very much that of providing for those who are proving to be a nuisance or an embarrassment in ways that removed them from general circulation. A primary distinction between people with mental illness and people with biological illness is that the former evoke a more complex and disturbing set of reactions in those that encounter them. As Scheff (1999) does, all of these suggest that one way of considering mental health difficulties is how they reflect or constitute disturbances of what social science refers to as social order.

Sociology's core business can be considered study of ways in which human beings associate with one another and develop patterns of activity that enable them to collaborate, communicate, share responsibilities for arranging shelter, food, child and healthcare, and defence against natural disaster or other competing human interests. At the heart of all of these is negotiation between the biologically autonomous individual or organism, and the rights and responsibilities that come with social association. Much of Western philosophy, political science and even theology is given over to discussing the nature, bases and dynamics of this social contract. The forms such debate have taken are located in historical and geographical context. In Europe, in recent times it begins with seventeenth-century moves away from the dominance of Divine authority over human affairs, and reflections upon other sources of political authority.[18] The debate moves on through Marxist analyses

[18] Hobbes, Locke and Rousseau are the established Enlightenment philosophers associated with this area.

based upon observations of the activities of groups (classes) with differing levels of access to material resources necessary for food, shelter and child care, to contemporary 'postmodern' approaches based upon analyses of shared meanings or discourses such as those presented by Michel Foucault.[19] What all these approaches share is recognition of the fact that human activity is or has become a complex set of interactions between individuals in which any one person's life is embedded in and influenced by others'.

Acknowledgment of this interconnectedness implies acknowledgement of constraint and a need to collaborate. Without collaboration with others, human lives would be 'solitary, poor, nasty, brutish and short'.[20] The evolutionary success of *Homo Sapiens* is undeniably attributable to the success and adaptability of its social capabilities. From a medical or biological perspective what these demand can be likened to the ways in which cells specialise to form a tissue, tissues to form an organ system and organ systems to form an organism. At root, each cell is an independent unit of life holding all that is needed to acquire essential nutrients, expel waste, adapt and reproduce. All of these are more successful if they can be carried out in an optimal environment, and so evolution has favoured the specialisation of individual cells into contributors to more complex systems of cells or tissues, which themselves play their parts in the even more complex organism. The success of an organism reflects how well it is able to maintain an internal environment that provides optimal conditions in which its constituent cells can function (homeostasis). This has meant that individual cells have had to become subject to the constraints of co-existence and specialisation. Although all living cells respire, consuming glucose, oxygen and other nutrients, and expelling carbon dioxide, urea and other wastes, not all reproduce freely, and certain capabilities such as specialised forms of secretion, and membrane or protein fibre growth are exaggerated in some but not others. The mechanics of these specialisations and related constraints are the stuff of molecular biology, in particular its applications to the study of tumour growth and tissue transplantation. Without complex systems ordering interactions and collaborations between cells, tissues cannot be viable, organ systems would not function and no complex organism would have evolved. Conversely, from a narrowly biological perspective, this ordering of cellular activity is the result of evolutionary forces selecting for arrangements that optimise the survival of individual cells.

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[19] Michel Foucault (1926–84). See *The Order of Things*, published in 1966 (2002).
[20] Thomas Hobbes, *Leviathan*, 1651.

Social systems can be considered in a similar way. Individuals flourish as a result of their participation in organised social arrangements, but, inescapably, this is at the cost of raw autonomy. There are many ways of framing this arrangement, and none of them amount to a complete explanation any more than molecular biologists can yet claim to have fully explained processes of cellular regulation and specialisation. Nevertheless, as with the biological analogy, there are certain broad and clear principles. One of these is that when social order is threatened, when an individual behaves in ways that challenge peaceful co-existence mechanisms designed to restore it are brought to bear. However else they might be conceptualised, mental health difficulties challenge peaceful co-existence, and responses to them can be thought of in these terms. As we have seen, conditions clearly understood as the result of biological frailty or physiological breakdown can be accommodated by a particular set of social arrangements that have developed over centuries in response to injury, sickness and death. Emotional and social disruptions that cannot be understood in this way evoke different reactions and activate a different set of social responses and arrangements. These are commonly very compelling, and often so automatic that action to repair or maintain social order is taken without comment or reflection. The maintenance of social order is so pervasive an activity that it generally proceeds reflexively and without question. The university lecturer who makes a pass at a student during a seminar will rapidly lose the respect they need to hold their post, and, quite possibly, the post itself. The doctor who loses their temper and shouts at a patient is heading for trouble, and an office worker who keeps unpredictable hours will attract critical attention. When conventions are broken a variety of responses follows, but the intention is to address the breach. We might focus upon the specifics of the case … the lecherous lecturer, the rude doctor or the unreliable office worker, but the reactions and sanctions they evoke are part of a larger picture, in which individuals' needs and expectations have to be subject to those of the larger number, or, in the case of a student or a patient, of the particular responsibilities towards those in their care. From a social sciences perspective the wider issue of social conformity, its transgressions and reactions to them are considered the study of deviance.[21] Considering mental health difficulties as instances of social deviance offers a way in which they can be

[21] The study of deviance is the social sciences field that focuses upon transgressions of social order, how they are recognised, sanctioned against and responded to.

considered through the lens of the social disruption they often cause. Considering mental health services as exercises in defending social order offers a way in which they can be understood, which explains some of their historic practices and the huge investment that continues to be made in them.

Social Deviance

The sociology of deviance considers subjects that are as widely distinct as serious crime and playground behaviour, and aspects of it that vary from how a behaviour comes to be identified as deviant, to the social and institutional arrangements such as courts and prisons that are put in place to contain it. From this vantage illness itself can be seen as a form of deviance, with a panoply of professionals, institutions, roles and commercial organisations all aligned around the tasks of accommodating infirm people and providing them with treatment intended to minimise or even reverse their infirmity. These are dominated by biomedical skills and facilities, and are only fully legitimate where and when deviance can be attributed to a biological cause. Talcott Parsons' outline of the roles and responsibilities of the sick and those who attend them applies well in these circumstances but less well in others.[22] Conrad and Schneider (1992) provide an account of the strains brought about by attempting to shoehorn other, more intuitively socially deviant behaviours such as alcoholism, domestic violence and delinquency into these social arrangements, and the particular case of mental health difficulties, which commonly evoke emotional reactions different from those immediately evoked by a sick person, are very much the subject of that discussion.

In very broad terms social responses to deviance, or exceptional behaviours and capabilities, can take one of several forms. The behaviour might be accommodated as tolerable, by those around the perpetrator making necessary adjustments. On a small scale this might be exemplified by a family accepting their teenager's choice of fashion. On a larger scale this is the approach adopted in order to accommodate the needs of physically disabled persons by the provision of ramps and other wheelchair-friendly facilities. This is predicated upon the fact that the deviance is not considered either immoral or unlawful and that accommodating changes are realistic. It is not realistic to make a

[22] See Williams' (2005) reflections upon contemporary applications of the classic sick role.

five-mile mountain track wheelchair friendly. If the teenager's choice of fashion includes relentless loud music or unpleasantly dirty clothes then the rest of the family might not be so accommodating. Under these circumstances the behaviour might be experienced as intolerably disturbing. This might also be the case when the perpetrator is clearly distressed, such as might happen when someone has become withdrawn and unsociable in response to job loss or a broken relationship. Under these circumstances loved ones are likely to counsel or coax the 'deviant' person towards feeling and/or behaving in a more amenable way.

More persistent or more troubling difficulties or deviances may be beyond the reach of everyday counsel and coaxing. Here, professional help might be sought. This is the point at which the problem becomes identified as something now subject to institutional rules and regulations. A noisy neighbour who hasn't responded to entreaties might become the subject of investigations into nuisance by environmental authorities. A pupil at school who has not responded to reasonable attempts to improve their classroom behaviour might become subject to more formal measures or even considerations of exclusion. Someone displaying continuing and apparently intractable emotional distress may prompt a call to the doctor. What triggers the involvement of others will vary with the nature and degree of the disturbance, the manner, resilience and relationships amongst the participants, and perceptions of the outsiders' skills and capabilities, but the involvement of professionals or the authorities is a critical step. The deviant behaviour passes from being a dispute between individuals to an activity that may or may not be an infringement of more widely recognised definitions of social order, with the possibility of formally enforced sanctions.[23] Certain forms of deviant behaviour that fall into this category are those that are defined by as illegal, by statute. These include most forms of dangerous, exploitative or violent behaviour, but even these are not always subject to formal evaluation and sanctions. People vary in their respect for

[23] The distinction between deviances that might be the subject of informal, spontaneous sanctions mediated through immediate relationships and formal sanctions applied by a specific body or agency with an eye to a particular set of norms is sociologically significant (Giddens and Sutton, 2013). It is related to Lemert's (1967) conceptualisations of primary and secondary deviance, which emphasise the part played by labelling. When a deviant act or individual becomes the subject of formal sanctions, the act or the individual becomes an institutional phenomenon, with implications for the perceived and/or experienced identity of the individual. This is of particular relevance to the process and consequences of medicalisation, or the identifying of a condition as an 'illness'.

authority. In some cases there may be a wish to protect the perpetrator from prosecution, or turn a blind eye to the activities of someone with power and influence, such as appears to have been the case in relation to Jimmy Saville's sexual proclivities.[24] In contrast, communal consent might fuel a witch hunt against the relatively innocent and vulnerable.[25] Informal responses to deviance are conducted through relationships between the identified deviant and those around them. Formal responses are the business of professionals and appointed authorities, but whether or not these are activated depends upon decisions made by those actually in the field, the actors concerned. Arbitrary though this might appear, the step from informal to formal responses or sanctions is critical. This is clearly the case when the deviance is a neighbourhood dispute or allegations of sexual abuse. The scene shifts irreversibly when the police are involved. From a sociological perspective the same forces are at play when someone with psychological or emotional difficulties, or their loved ones, seek help from the doctor.

Seeking Help

As the illustrative referral letters of Chapter 6 demonstrate, referral to specialised mental health services is an important step, and it is usually taken because the patient is behaving in a particularly disturbing way. In turn, such a referral can only happen if the patient or their loved one has sought help from a doctor in the first place, unless the problem is the relatively rare event of a crisis occurring in a public place. As the foregoing discussion of deviance suggests, this first trip to the doctor is often only taken after diligent and frequently wearing attempts to accommodate the distressed person in less formal ways. Subsequently, the bar might be lower.

Determinants of going to the doctor have been researched from a variety of positions in a variety of contexts and in relation to a variety of conditions. Current opinion favours a complex systems approach in which bodily processes and experience of them, individual support

[24] Jimmy Saville was a British celebrity who died in 2011. He was feted for his charitable works in support of the disabled. After his death it emerged that he had used positions of trust to sexually exploit minors, and that these activities had been overlooked by responsible others in awe of his reputation.

[25] For instance, Bijan Ebrahimi, who was a vulnerable Muslim immigrant to Britain from Iran, was beaten to death in 2012 by a group of young men on a Bristol housing estate at the end of several years' racially mediated taunting and abuse.

systems or personal networks, the institutional setting such as place of residence and perceived availability of services, and cultural setting, which includes generally held beliefs about illness and treatments, all interact to determine the outcome.[26] This has been investigated in detail in relation the progress of young people navigating their way forward in relation to mental health difficulties. Findings are that the path is tortuous and idiosyncratic.[27] The decision to seek the doctor's help with or by someone who is emotionally or psychologically distressed cannot be considered in isolation. It is always the outcome of complex interactions between the nature and intensity of their difficulties, the forbearance of those around them, other details of the situation and the understandings all concerned have of the difficulties they are encountering and what the doctor might be able to do in response. Even so, when that step is taken, an important threshold is crossed. The difficulties cease to be a form of deviance that might be contained and accommodated by adjustments to relationships and other arrangements in the patient's immediate circle. They become the object of professional actions and they are subject to institutional logics and practices.

Consequences of this reflect those logics and practices. If the institutional setting, in other words 'going to the doctor', is one that affirms and supports earlier attempts to counsel and coax, offering understanding and dialogue with a view to enabling all concerned find more successful ways of accommodating the distress, then attempts to contain 'deviances' within the existing framework of relationships and other arrangements can continue. If, instead, the problem is understood as an illness, a completely different course opens up.

A doctor is likely to identify emotional and/or psychological difficulties as 'illness' for a variety of reasons. First among these is that the difficulties take a form that they have learned to recognise as mental illness, such as voice hearing, grandiose behaviour and beliefs or disabling compulsions such as repeated checking. Another is that the difficulties include or appear to threaten dangerous behaviour such as self-harm or violence to

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[26] Pescosolido (2013) presents these complex interactions as a model framework upon which to consider and investigate differing interacting elements of the determinants of individuals' choices of action in relation to illness and healthcare.
[27] A detailed study of young adults' use of primary care services for support with emotional/psychological difficulties concluded that their progress was 'part of a broader, protracted and fluid process of interpretation and varied actions' (Biddle et al., 2007).

others, and a third is that those making up the patient's immediate circle are exhausted and have no remaining tolerance. The first of these reflects medical education and fashions of practice, the second public perceptions of risk, and the third, social or lay understandings of what can or should be expected. Stepping over the boundary in any one of these ways amounts to stepping up the scale of response to deviances to where the patient becomes the object of authoritative, professional opinion rather than an active participant in dialogue. As in other situations in which deviant behaviour demands an authoritative response, such as the intransigent noisy neighbour or the disruptive pupil, taking that step might well be experienced as the only sensible course, and it might well be widely condoned, but, as with these other responses to deviance, it is not without untoward consequences.

Medicalisation

Once a distressed person becomes a *source* of distress and difficulty rather than an active participant in difficult circumstances, they quickly become a problem to be solved rather than a person to be understood. So often the task becomes that of treating the illness rather than understanding how the situation has come about. This can make the situation worse. Once identified as someone with a mental health problem, a person's actions and feelings lose any validity they might have had in the eyes of others. Whatever the suffering person might be experiencing, as far as others are concerned it is unreal and alien. In the eyes of others, distressing and difficult emotions and behaviour become the consequences of an illness; problems to be corrected and put right rather than genuine and legitimate experiences, however mistaken. There are obvious attractions to this, in the same way that there are attractions in calling the police rather than remonstrating with that troublesome neighbour, but doing so shifts the dispute into another domain. Unwelcome behaviours such as inexplicable anger, suspicion, recklessness or undue dependency are difficult to live with, and they are much easier to accommodate if thought of as signs of an illness. Doing so offers relief from any sense of responsibility for fully engaging with the unwanted feelings and actions. Unfortunately, it also distances other participants from the full reality of the patient's life. An emotional and behavioural barrier is erected, commonly for understandable reasons of self-preservation but nevertheless with unintended and frequently unhelpful consequences.

'Illness Like any Other?'

Much has been written about the nature and effects of stigmatising people with mental health difficulties, but for many psychiatrists stigmatisation and its consequences are regrettable social phenomena that impact upon their patients for reasons that are beyond their remit and in ways they cannot control. For most of those who suffer mental health difficulties stigma and social exclusion are the heaviest burdens they have to bear. Interestingly, the more firmly a mental health difficulty is cast in the mould of an illness, the more stigmatisation it seems to attract.[28] This is a challenge to the many who argue that association with medicine's philanthropic orientation should reduce stigmatisation of those with mental health difficulties. If mental illnesses are deemed 'illnesses like any other', then, surely, those who suffer them should enjoy the philanthropy and understanding extended to everyone who is unwell? This overlooks an essential feature of mental health difficulties. The difficulties themselves cannot be separated from the person experiencing them. A person with a broken leg, cancer or heart disease is a person with a broken leg, cancer or heart disease, and although they may be frustrated, anxious or unhappy as a result, these emotional reactions are accommodated and understood as consequences of their condition. A person who is depressed or anxious, or who is hearing voices is primarily a source of concern to others because of their emotional difficulties. Although it is relatively easy to imagine, if not share, the emotional pain of someone with a clearly apparent physical illness, extending the same philanthropic understanding to one whose emotional pain is difficult to follow or understand is a different task, and one that is all too commonly replaced by self-defensive emotional distancing.

Were it possible to locate the cause of someone's emotional or biological difficulties firmly and effectively in the biomedical sphere, then

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[28] Angermeyer et al. (2013) investigated change in attitudes to people with mental illness among the German general public between 1990 and 2011. They found that although there was greater sympathy for mental health professionals, an increased tendency to view schizophrenia as a biomedical condition was associated with a stronger desire for social distance. Viewing people with schizophrenia as suffering an illness makes it more difficult to relate to them. Read et al. (2006) identified 21 studies originating from eight different countries that were able to associate whether or not subjects viewed schizophrenia as a biomedical or a psychosocial condition, and their attitudes towards those afflicted. In all but one instance a tendency to view the condition a biomedical one was associated with less sympathetic attitudes.

it could be possible to separate their condition from the person, and genuinely enjoy the socially supportive advantages of 'illness like any other'. Unfortunately, that is either impossible or, if it is possible, takes a form that risks unnecessary social harm. More than 50 years' psychopharmaceutical research has resulted in what appears to be a dead end, where the complexities of the human brain have outwitted attempts to identify any one set of behaviours, deviant or otherwise, with any one particular set of neurochemical interactions that might be the target of conventionally applied drug treatment. The more sensitive and detailed neuroimaging has become, the more closely what it reveals approximates to the fluidity and complexity of human behaviour as observed in the course of everyday interactions and relationships. Research into genetic predispositions to 'mental illness' has yet to identify biological substrates of the troubling behaviours that are classified as such. One should never say 'never', but even the most committed neuroscientist will acknowledge that we do not have an effective biomedical grip upon human behaviour and its more troublesome excrescences. How different the world would be if it really was possible to control violent behaviour, tribal conflict or corporate greed as biological mechanisms operating within the individual. Current knowledge of depression, anxiety, most psychoses, addictions, obsessional and compulsive disorders, and personality problems gets nowhere near this and, given their inescapable sensitivity to interpersonal and developmental influences, for many it is an act of faith that they ever will. By definition, psychiatry is concerned with difficulties best thought of as 'all in the mind', and that means difficulties primarily identified by their effects upon relationships and other features of social order. These follow logics and require approaches that are different from those that define and comprise medical thinking and practices. This is no small challenge but it is where a careful and critical appraisal of what psychiatry is called to do and the knowledge and skills it has available to do it with arrive at. The implications of this for how psychiatry might be better understood, what might be expected of it and how that might be made available are considered in Chapter 8.

8
So what can be Learned?

The overview of contemporary psychiatry's tasks and tools in the body of this book can be thought of as a summary of findings from a 50-year experiment. Beginning in the 1960s, psychiatry set out, consciously or otherwise, to develop and present itself as a medical specialty equivalent to any other in logical framework, status and a commitment to science. During the first half of the twentieth century psychiatry had backed two horses. One was the care of and amelioration of suffering amongst those incarcerated in large numbers in overcrowded asylums. The other was the interpretation and resolution of psychological conflicts considered to be the source of difficulties and distress. Beginning in the 1950s pressures to run down the asylum system, promises of chemical cures and embarrassment at not being able to join the rest of medicine's embrace of science all conspired to fuel change. This resulted in a reliable scheme for classifying mental health difficulties, investment in scientifically inspired approaches to studying them and the presentation of psychiatry to its public as a professional enterprise 'doing' scientific medicine just like its peers in cardiology or neurology. A chorus of critical voices suggests that this has not met with sucess or with universal approval, and the main purpose of this book has been to gather findings from the experiment and distil what can be learned from them. They can be boiled down to three related statements:

- currently influential classifications of mental health difficulties do not identify distinct disease entities as these are understood elsewhere in medicine
- the search for targeted chemical cures for specific mental health difficulties has been unsuccessful—the full effects of psychiatric medication can only be understood by taking account of the indirect and nonchemical aspects of prescribing and administering it

- therapeutic gains attributable to mental health professionals are largely a result of the helpful and supportive relationships they develop with their clientele.

These are challenging conclusions and not everyone, particularly not those with an investment in either providing or receiving conventional forms of care, would agree with them. Nevertheless, a clear and compelling refutation of any one of them doesn't emerge from the facts. Knowledge changes and develops, and there is always the possibility that the future will bring a sufficiently comprehensive scientific understanding of human behaviour that can underpin bodily interventions capable of safely and reliably manipulating it. At present that is technically, morally and ethically very distant. If any respect can be given to the findings of psychiatry's 50-year exploration of how well science can or cannot support its purposes, then the conclusion has to be 'not very much'. As a result, insofar as medicine is crafted and presented as a scientific endeavour, psychiatry continues to sit uneasily within it. This is very much what Sir Denis Hill said in 1959, just as the experiment was beginning to get under way.[1] These conclusions would also be familiar to Thomas Szasz,[2] and must be to readers who are sympathetic with his views. Szasz's seminal work, *The Myth of Mental Illness* was first published in 1961, and it has stood as a landmark amongst criticisms of medical approaches to mental health difficulties ever since. The privilege of hearing Szasz speak in London after 50 years of defending this work was a reminder of how well developed his position is, and how effectively he defended it. Szasz was known by his detractors, of course, as a leading voice amongst those who have been dubbed 'antipsychiatrists', some of whom might also call themselves 'abolutionists'.[3] A consequence of these somewhat pejorative terms is that debate about the nature and purposes of psychiatry has fallen into an unhelpful tribal conflict between those who view medical, scientific

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[1] See the reference to a presentation given in 1959 also mentioned in the Introduction (Hill, 1960).

[2] Thomas Szasz (1920–2012) is also referred to elsewhere (see note 17, Introduction).

[3] Many, particularly some of those who have experienced coercive treatment in psychiatric facilities, have taken the view that psychiatry is a form of oppression, of politically generated social control and therefore a legitimate target of organised political action. Examples of this position can be found in Burstow et al. (2014).

psychiatry as effective and desirable, and those who view it otherwise.[4] Rather than open mindedly reflecting upon what can be gleaned from half a century or more's experience of attempting to address mental health difficulties from a medical perspective those in the field, those obliged to use mental health services and external commentators have tended to adopt and defend particular positions. Before moving on to consider what can be learned from a less confrontational perspective it is helpful to review the sources of this unproductive debate, with a view to leaving it behind.

The Origins of 'Antipsychiatry' and its Legacy

First use of the term 'antipsychiatry' is attributed to David Cooper,[5] although British criticisms of psychiatry and its practices have a much longer history,[6] and various form of expression throughout the nineteenth and twentieth centuries.[7] Parallel developments in the USA include Elizabeth Packard's Anti-Insane Asylum Society.[8] This had origins in her experiences of incarceration at her husband's hand in

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[4] See, for instance, the public exchange of views exemplified by a group of primarily biomedical psychiatrists writing in the *British Journal of Psychiatry* in 2008 (Craddock et al., 2008), and a broader reflection upon the social role of psychiatry offered by Pilgrim and Rogers (2009).

[5] David Cooper (1931–86), a psychiatrist of South African origin, published *Psychiatry and Anti-Psychiatry* in 1967.

[6] Hervey (1986) outlines some of the ways in which the 'mad' were exploited and abused in eighteenth century madhouses, and establishment of the Alleged Lunatics' Friend Society in England in the mid-nineteenth century to challenge the system and campaign for rights and reforms.

[7] The Alleged Lunatics' Friend Society was superseded by the Lunacy Law Reform Association (1873) with the explicit object of obtaining 'increased safeguards against wrongful incarceration of the sane, with ameliorations in the treatment of lunatics'. In 1874 it published a first report in which apparently 'they make a series of charges all round, of brutal cruelty, political influence, and criminal negligence on the part of medical men in signing lunacy certificates'. The After-care Association for Poor and Friendless Female Convalescents on Leaving Asylums for the Insane was formed in 1879. It became the Mental After Care Association, which continued until 2005. The National Council for Mental Hygiene was formed in 1922, and the National Association for Mental Health was formed in 1946. This became MIND in 1972 and, as such, it remains a leading mental health advocacy organisation.

[8] Elizabeth Packard (1816–97) was held in Jacksonville Insane Asylum, Illinois, for three years on account of theological differences with her husband and released only after legal proceedings.

response to religious and other domestic differences. Dain (1986) draws attention to other theological objections to psychiatry of the time, in particular those arising from the growing Christian Scientist movement. Szasz himself was to become closely associated with Scientology.

The particular characteristics of 'antipsychiatry' as the term is currently used are twofold. Firstly, it developed quite specifically out of associations between psychiatrists and other more politically oriented commentators during the late 1960s; and, secondly, as a result, it has become available as a rhetorical turn that can be used to close down debate concerning psychiatry's shortcomings by associating critics with a politicised agenda. Much of antipsychiatry's notoriety and influence grew out of R.D. Laing's association with other aspects of late-1960s counterculture. His criticisms of contemporary psychiatric practice became associated with wider social critique.[9] As a result, those who dared to criticise medical psychiatry were readily identified as unrealistic ideologues promoting radical social and political change towards an anarchic or Marxist utopia. His and others' more narrowly focused commentary upon psychiatric practice was lost. Although a more thorough account of the antipsychiatry movement would include others,[10] the views of Laing and Szasz have come to represent the two quite different positions crudely brought together by critics under the umbrella of 'antipsychiatry'. In fact, both Laing and Szasz expressly disavowed description of themselves as 'antipsychiatrists', but the mud has stuck and the term remains identified with them and their positions. In Szasz's case the stereotype has been that of a harsh neoliberal ideologue unconcerned for the suffering of those otherwise deemed to have mental illness, and in Laing's case that of a starry-eyed left-wing idealist agitating for something that could only be realised by the collapse of society as we know it. To associate any substantive criticism of psychiatry with one or other of these positions effectively shuts down debate, and it is barely surprising that this has hindered healthy discussion. Anyone who dares to suggest that the medical approach to psychiatry

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[9] Crossley (1998, 2006) provides two complementary accounts of how the British antipsychiatry movement can be understood as the outcome of a multifaceted set of influences rather than a particular 'movement', and of R.D. Laing's contribution to it.

[10] Others have to include Jacques Lacan (1901–81), who approached criticisms of psychiatry from a psychoanalytic perspective; David Cooper (1931–86) and Peter Sedgwick (1934–83), who did so from a political perspective; Francis Basaglia (1924–86), who led de-institutionalisation of mental health care in Italy; and the indirect influences of Michel Foucault's work (1926–84).

might not be what it purports to be is immediately associated with Szasz, and anyone who dares to suggest that psychiatry is primarily concerned with the maintenance of social order is immediately associated with Laing.

This is a sterile position. As arguments presented in Chapters 2 and 4 outline, a narrowly medical approach to mental health difficulties has to answer a number of legitimate criticisms. The material and arguments presented in Chapters 6 and 7 draw attention to the traditional and continuing role of mental health services in the maintenance of social order, something that is a necessary feature of civilisation and which has to be supported in a variety of ways if it's benefits are to be enjoyed. Chapter 5 draws attention to the fact that much can be achieved by deliberately reaching out to those otherwise excluded from meaningful social participation, and how mental health services, explicitly or otherwise, do indeed play an important part in this. Clinical and intellectual progress will only be at their best if related debate incorporates these findings. They arise from a careful reading of evidence accumulated over the several decades' experiment whereby the validity of approaching mental health difficulties as 'illnesses like any other' has been tested. Such findings can be challenged, but they are the result of interpreting evidence rather than expressions of an ideological position. As a result, challenges to them can only be credible if they too engage with available evidence, and move away from the sterility of ideological confrontation.

As already indicated, the evidence can be distilled into three conclusions concerning the nature of mental health difficulties and services currently made available to provide for them. As a contribution to more mature debate the implications of each of these is now considered in more detail. The aim continues to be that of providing students, trainees, mental health service users and those associated with them a richer, more honest and informative view of what psychiatry is, is not and might be capable of.

Currently Influential Classifications of Mental Health Difficulties do not Identify Distinct Disease Entities as these are Understood Elsewhere in Medicine

This is an established argument well presented in a number of other places, and covered here in Chapter 2. Of primary concern are the misunderstandings that have resulted from shrouding mental health difficulties in a cloak of medical terminology and logic. Words such as

'illness', 'disease' and 'medical diagnosis' have particular meanings and connotations drawn from how they are used in medicine more widely. Their use in relation to mental health difficulties conveys implications that are not necessarily always justified. 'Illness' refers to a state of affairs in which someone is disabled by discomfort and impaired capability in ways that are generally and consensually agreed to justify the sanctions and privileges of the sick role. They are deemed to be incapacitated for reasons beyond their own control, and common humanity insists that they should be relieved of responsibilities and cared for. Whether or not a particular condition or set of circumstances merits these socially costly arrangements is a judgement made and agreed by convention, albeit one that is commonly informed by professional medical knowledge and opinion. When a condition or a set of circumstances is judged to be a 'disease', specialised medical knowledge is implied. This might be because the judgement has been made by a trained and therefore authorised healthcare practitioner, or because it has been made by a 'lay' person on the basis of informally or even assiduously acquired medical knowledge. Identifying a disabling condition as a disease implies the presence of specialised medical insight into abnormalities of bodily function that can explain it. 'Medical diagnosis' is the process of elucidating abnormalities of bodily function that provide such explanations. Mental health difficulties are not understood by anyone in terms of underlying abnormalities of bodily function; indeed, when they are they cease to be seen as 'psychiatric', as has happened historically with epilepsy and senile dementia, and happens occasionally in everyday practice when a disturbed person turns out to have a brain tumour or to have had a stroke. As Chapter 7 argues, psychiatry is explicitly concerned with conditions and situations that defy a bodily explanation; in other words, conditions and situations that are not helpfully discussed in terms of 'disease', 'pathology' or 'medical diagnosis' as these terms are used elsewhere. Their espousal by psychiatry has to be understood as either a misappropriation or a controversial and unclear evolution of their meanings.

Szasz was clear that it was the former. Using very much the same arguments mustered here in Chapter 2, he insisted that 'mental illness' was a myth and he firmly maintained a critical position reflecting this for half a century. That half century has seen a huge growth in medical psychiatry, ever-increasing numbers of people 'diagnosed' with 'mental illness' and ever-increasing numbers of prescriptions for psychotropic medications. If the views of Szasz and other critics had fallen on fertile ground or reached receptive ears the outcome might have been

different, but that didn't happen. For many, the presence of a mental illness is an accessible and enticing way of understanding a wide range of human difficulties. Instead, it was the views of pro-psychiatrists such as Roth and Guze, arguing, respectively, that mental illness is 'real' and that psychiatry is a 'branch of medicine' that fell on fertile ground (see Roth and Kroll (1986) and Guze (1992)). There are many commentaries upon this that invoke more or less conspiratorial interpretations of influences by the pharmaceutical industry, guild interests amongst psychiatrists and the interests of healthcare commissioners,[11] which are best dealt with elsewhere. What is at least, if not more, important is to address the question 'Does it matter?' Is there any harm in applying the logics of medicine to mental health difficulties, and, if there is, what is it and what are the alternatives?

Conspiratorial interpretations of vested interests apart, one of the reasons why critiques of medical psychiatry have fallen on stony ground and support for medical psychiatry has found fertile ground is the attraction of simple solutions to difficult problems. As Chapter 6 illustrates, the situations in which psychiatry is called upon are commonly tragic or very distressing disturbances of human conduct. Historically, there is nothing new about this. Co-locating them with the rest of medicine is a relatively recent development, which provides grounds for philanthropy and legitimises the commitment of resources, which can only be good for all concerned. Unfortunately, that has proved to be a double-edged sword as it also sets up expectations that may be hard to fulfil, and it identifies a social space with uncertain boundaries and attendant confusion.

Unfulfillable Expectations

Medicine and its clientele are well acquainted with the limits of its capabilities. Sad though it might be when it happens, few dispute the legitimacy of a medical judgement that concludes 'incurable', 'irreversible' or 'permanently disabling' when it is clear this has been made on the basis of thorough investigations employing generally agreed standards of medical technology and knowledge. The prospect of dying as a result of widely disseminated cancer; permanent paralysis after a spinal injury; stiff, painful and perhaps immovable joints affected by arthritis; or blindness due to diabetes are all tragedies, but they are rarely disputed or a source of disappointment with healthcare if it has been

[11] See note 9, Chapter 4, and Luhrman (2001).

conducted with appropriate and due diligence. It is generally accepted that there are limits to what medicine can achieve. We know enough about cancer to accept that from time to time it spreads throughout the body and in ways that make it untreatable; we know that a serious spinal injury can so damage the spinal cord that permanent paralysis is the result; we know that some forms of arthritis cause so much damage to certain joints that they can become unusable; we know that one of the complications of diabetes is degeneration of blood vessels in the retina resulting in impaired vision; and we accept the consequences of all of these outcomes. We are satisfied that these explanations are derived from agreed medical knowledge and provide a sufficient explanation for what has happened, and therefore reluctantly but realistically accept a tragic and disappointing outcome. Where medical opinion is unable to provide this certainty the situation can be different, as it is when hopes are raised by the possibility of cure by unconventional and less widely adopted means, or, of course, in the case of mental health difficulties. One of the harmful consequences of co-locating mental health difficulties with the rest of medicine is that doing so raises unfulfillable expectations, and this can compound pre-existing difficulties and distress. When it is clear that a paralysis is irreversible or blindness is inevitable, routes towards adapting and coming to terms with the situation open up. There are wheelchairs, white sticks and braille to learn about. Such prospects may not be attractive but if their need is based upon authoritative medical opinion then it can be accepted and embraced. Medical psychiatry is unable to provide such certainty. A common consequence is clients accepting a line of treatment that does not turn out to fully alleviate their distress, but without authoritative acknowledgment that there isn't another one that will. Rather than considering that their difficulties might be better understood as a tangle of difficult relationships, their voices an unwelcome but manageable mental experience, their misery and withdrawal attributable to a painful loss, their anger and conflicts consequences of how they habitually relate to others or that their phobias and fears are understandably maintained by routines of avoidance, failures to get better may be experienced as inadequate treatment. Practitioners drawn into this might try one line of treatment after another with only limited success and escalating frustration on both sides until the arrangement breaks down or the client receives the unspoken message that medical psychiatry isn't going to help. This is often a very messy and distressing process. It is consequent upon a lack of well-founded and generally agreed medical knowledge, which could otherwise authorise the view that continuing to search for an effective

treatment is futile. It is not uncommon in situations where hope has been pinned upon a medical treatment and it commonly interferes with a search for other ways of considering the difficulties. It commonly compounds clients' difficulties.

Untoward Consequences of the Sick Role

Another effect of conceptually co-locating mental health services with the rest of medicine is that it also co-locates psychiatric clientele with the sick. From a sociological perspective, being sick or being ill is a well-defined social position, a form of sanctioned deviance.[12] As a socially sanctioned phenomenon the sick role is socially constructed and licensed by convention. It is applied to certain disabling conditions and situations, but not to others. Repeated petty theft and paedophilia may be compulsions resulting in a very limited life but, for a variety of reasons, perpetrators are not accorded privileges of the sick role; instead, they are considered criminals. Assumed or fictitious disability that has been adopted for financial or other benefit is considered malingering and frowned upon. The relief from responsibilities and expectations of being cared for that come with the sick role are only available in situations that qualify, and although that can apply without direct medical authorisation, as in a bout of 'flu or food poisoning, the judgement is essentially, also, medical by proxy. 'Flu or food poisoning qualify as real illnesses justifying privileges of the sick role because there is likely to be general agreement that, were a doctor or another healthcare practitioner to attend, there would be little doubt about what was wrong. Thus, the stipulations of the sick role apply in situations where general consensus and medical opinion concur.

Although the sick role incorporates privileges, it also incorporates obligations to assume a limited social role. These conflict with notions of autonomy and self-efficacy, and although they might be acceptable to someone welcoming and benefitting from privileges of the sick role while laid out with 'flu or food poisoning for a few days, being patronised and left out of the loop are not much fun if there is no gain or necessity. Furthermore, the obligations of the sick role are at odds with certain aspects of the process of recovery from mental health difficulties. Humanistic–existential and transpersonal approaches to psychotherapy draw attention to the importance of self-actualisation, self-realisation and personal agency to psychological well-being. These

[12] See discussion of the sick role in note 12, Chapter 2.

are the core features of what is aspired to as 'recovery' by most of those seeking it,[13] and it is not difficult to see how they conflict with obligations associated with the sick role. A striking example of how wider appreciation of ways in which a patronising approach to enduring disability has been recognised as unhelpful and has changed is the shift in attitudes towards the physically disabled that occurred during the twentieth century.[14]

One of the benefits of the co-locating of mental health services with the rest of medicine is that it has brought the power and philanthropic reputation of medicine to bear upon a constituency that has otherwise been neglected. Almost by definition, people with mental health difficulties are marginalised and unwanted. They suffer the demeanour of being stigmatised and, traditionally, in public service settings, they have been provided for very poorly. In the UK, the Royal College of Psychiatrists champions parity of esteem between mental health services and other aspects of healthcare in pursuit of better investment in what they do and the services provided for their clients (see Royal College of Psychiatrists, 2013). Given its concern for the sick, medicine is a powerful lobby in debates over the allocation of public funds, and identifying with it is an effective way of attracting support. At a more personal level, the sick role can be attractive, and in the short term at least, particularly so to one afflicted with mental health difficulties and their associates. The difficulty acquires a name and appears to be comprehensible (diagnosis). It is presented as susceptible to professional intervention. It is not anyone's 'fault'. As an illness it licenses relief

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[13] There have been other definitions of 'recovery', which include the alleviation of symptoms, return to a satisfactory level of functioning and discharge from professional care. Acquisition or resumption of autonomous self-hood is what most service-user advocates and those identifying themselves as experts with experience of mental health services mean by the term, and this is consistent with these theoretical perspectives (see Pilgrim and McCranie, 2013)

[14] Compare the portrayal of Colin in *The Secret Garden* by Frances Hodgson Burnett, which was first published in full in 1911, and the activities and acclaim of the 2012 Paralympic Games. Consistent with attitudes and practices of the day Colin, a boy considered to be disabled by a spinal deformity, was kept sequestered and in care until he was redeemed by his cousin Mary. Mary had to challenge her elders, medical opinion and those conventions in order to do this. The very idea of organised competitive sporting events that include the physically disabled had to wait until the middle of the century, and the success of their entry into the Olympics goes without further comment. These developments in the sporting world parallel other developments in attitudes towards and facilities supporting those who in earlier times would have been marginalised and patronised.

from responsibilities and promotes expectations of being looked after. In times of emotional turmoil all of these can be powerful sources of relief and reassurance, and in combination even more so. However, the sick role also comes with disempowering obligations. Longer-term occupancy of the role results in dependency, a loss of personal agency and distortions of self-perception towards incompetence and incapacity. All of these mitigate against recovery; indeed, many who have found their way out of serious mental health difficulties testify to the importance of eschewing the sick role in the process (see, e.g., Romme et al., 2009). Where there is medical knowledge able to provide an external point of reference, applicability of the sick role can be judged against it in ways that all concerned can agree with and work to. 'Your temperature is still raised or these blood tests are still abnormal and so it's not time to go back to work yet.' 'Come on, that was awful but the X-rays show that your pneumonia has cleared up and it's time to get back on your feet.' 'I am very sorry but the MRI [magnetic resonance imaging] scans and nerve conduction studies are clear that your spinal cord isn't going to heal. You have to start thinking about what it will mean to live in a wheelchair.' Not all of these will be immediately popular to every patient but, grounded as they can be in externally verifiable medical evidence, they are respected, however grudgingly. By definition, mental health difficulties do not come with access to sources of externally verifiable medical evidence. Their manifestations are largely subjective and judgements about whether or not someone is truly 'ill' in this way are either made on the basis of whether or not their difficulties conform to certain arbitrary criteria, or on the basis of the degree to which they are causing others distress.

Neither of these constitutes a clear, consensually agreed external point of reference and, as a result, many suffering mental health difficulties find themselves in an uncertain social space. They might wish to resume full competence and autonomy but others around them, who could include healthcare practitioners, might be concerned that understandable anxieties and diffidence about this are evidence of continuing 'illness'. Thus, they may be restrained from taking risks, from trusting their own judgements and resuming responsible autonomy. In some such cases others' concerns might be justified, and the result is someone reluctantly obliged to accept paternalistic oversight, even sometimes legally enforceable constraints. In other cases, there may be differences of opinion among a clients' associates over whether or not it is right to release them from obligations of the sick role and promote autonomy. This is not uncommon following an episode of self-harm, something

that can be very disturbing for the self-harmer's family and friends but not so disturbing to a seasoned mental health practitioner who has seen many such incidents pass without recurrence and who has some skill in spotting the occasional instance of truly worrying suicidality. Under these circumstances the client might well receive different messages from their healthcare practitioners and from family and friends, with resulting doubt and confusion about their own safety. Sometimes a client might be reluctant to leave the sick role. It does carry privileges, and the prospect of resuming full autonomy and responsibilities might be daunting. However, if and when this is associated with a professional view that there is no arguable justification to continue in that role other than a reluctance to change, the result can be conflict. Not uncommonly this is marked by episodes in which the client seeks to demonstrate the depth of their despair by acting in a risky or distressed manner. These tend to elicit polarised reactions amongst practitioners either intimidated by the apparent risks or angered by the experience of being manipulated. Neither are helpful. As it is simultaneously a widely acknowledged and well-defined gateway into being acknowledged as a person in difficulties and justifiably in need of care and support, and a social role that requires submission to authority and a loss of independence and autonomy, the sick role is an imperfect arrangement wherein to accommodate mental health difficulties.[15] Nevertheless, it has a defining influence upon relationships between healthcare practitioners and their clientele, and it provides a framework for the disbursement of funds in support of the needy.[16] Together these amount to inescapable reasons why engaging with stipulations of the classic sick role are

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[15] May and Kelly (1982) report experiences of patients in 1970s asylum wards who did not conform to expectations of the classic sick role. There was considerably more conflict and frustration with those who didn't than with those who did, illustrating the extent to which even that setting was ordered around conventional views of the patient's demeanour and the readiness with which their behaviour conformed to conventional expectations of relationships between carers and the cared for.

[16] Who should and who should not receive alms has been a central debate in what might now be considered social policy circles from at least as long ago as 1601. The Poor Relief Act of that date distinguished between the impotent poor (mainly those who were 'lame, impotent, old, blind'), who were to be provided for in almshouses; the able-bodied poor, who were to be set to work in a house of industry; and idle poor and vagrants who were to be sent to a house of correction or even to prison. One way or another of policing these distinctions has been a central feature of welfare policy ever since. Provisions and expectations of the sick role clearly relate to them.

unavoidable consequences of co-locating mental health difficulties with the rest of medicine, even if doing commonly results in contentious consequences.

The Search for Targeted Chemical Cures for Specific Mental Health Difficulties has been Unsuccessful. The Full Effects of Psychiatric Medication can only be Understood by Taking Account of the Indirect and Nonchemical Aspects of Prescribing and Administering it

There are at least three sets of implications stemming from this conclusion. Firstly, it is misleading to claim that when psychiatric medicines are used, doing so is comparable with treatment of a disease or correction of an abnormality, as might be the case when a course of antibiotics is used to combat an infection or someone with diabetes uses insulin. Secondly, given the lack of knowledge concerning the effects of psychiatric medicines, prescribing them is not an exact science but something that has to be tailored to each recipient's experience of them. Thirdly, much remains to be discovered about the complex interactions between the direct and indirect effects of psychiatric medicines, clients' expectations of them, the circumstances in which they are prescribed and administered, and clients' experiences of taking them. These implications are not independent of one another and together they point towards a pressing need to re-evaluate psychiatry's relationship with medical treatment, but for the sake of clarity they are best considered in turn.

Disease-centred or Drug-centred Treatment Effects

Following the decision by the National Institute of Mental Health (NIMH) to steer away from clinical diagnostic criteria as a research framework,[17] surely only the most dyed-in-the-wool psychopharmacologist can continue to argue that this, that or the third medicine is a treatment for this, that or the third mental illness. Unfortunately, the regulatory framework insists that they do. Prescription-only medicines have to be licensed by the appropriate authority, in the UK the Medicines and Healthcare Products Regulatory Authority and in the US the Food and Drug Administration. Other jurisdictions have their own regulatory bodies and procedures. Acquiring a licence to market a pharmaceutical is a demanding process involving a series of steps or phases, but, in essence, it amounts to submitting evidence of sufficient quality

[17] See notes 7 and 8, Chapter 4.

to demonstrate to the authority's satisfaction that the product in question is safe and effective. In this context, 'effective' means measurable clinical improvement in people suffering a specified disease. Clearly, it would be nonsense to license a product without specifying the condition it is licensed for. Diuretics and certain antibiotics are undoubtedly safe and effective treatments for heart failure and pneumonia, respectively, but it would be nonsense to suggest that a new antibiotic could be used in the treatment of heart failure, or a new diuretic in the treatment of pneumonia. Thus, those developing and setting out to market a new psychopharmaceutical have had to specify the mental illness their product is intended to treat. NIMH's move away from the Diagnostic and Statistical Manual of Mental Disorders (DSM) and other diagnostic frameworks is high-level scientific acknowledgment that it is unrealistic to identify any one psychiatric condition with any one set of chemical abnormalities, or its treatment with any one set of pharmacological properties. Nevertheless, the regulatory authorities require evidence that demonstrates that '*this* medicine is a safe and effective treatment for *this* condition', and so preparing a case for licensing is primarily a matter of amassing data that make such a case. Marketing a pharmaceutical product once it has been licensed has to follow the same rules: '*this* medicine has been licensed for the treatment of *this* condition'. The whole structure of medicines licensing, the language it obliges pharmaceutical companies to use in their publicity and, as a result, how healthcare commissioning organisations choose to pay providers and for medicines all paradoxically compound the fiction that any one mental illness can be identified with a particular abnormality of brain chemistry. Medicines licensing is a very influential set of statutory processes and, as currently applied to psychopharmaceuticals, it perpetuates that myth.

Many have argued that the development of compartmentalised, categorical definitions of mental illnesses such as those embodied in DSM and the International Classification of Diseases (ICD) reflects a conspiratorial association between academic psychiatrists and the pharmaceutical industry, as the latter has sought to negotiate requirements of the licensing process in the course of developing its business. This is not the place to go into questions of conspiracy. Others have focused upon that interpretation of the last 50 years' development of 'medical' psychiatry,[18] but there is no doubt that there has been scope for a synergy. The clear 'diagnostic' criteria provided by DSM and ICD have made it possible for pharmaceutical companies to test their products in

[18] See the various publications referred to in note 9, Chapter 4.

a way that satisfies the regulatory authorities. It is a sad paradox that the very same statutory arrangements put in place to protect prescribers and the public from unwarranted and misleading claims have, in this field, compounded a misleading fiction. Psychopharmaceuticals do have effects and sometimes these are beneficial, but not in the sense of a 'treatment' for a particular 'disease'. A more honest approach would be to frame the value of a drug in terms of whether or not it is effects are experienced as safely more beneficial than other approaches among people troubled in particular ways, people tortured by unpleasant voices, people frightened to leave the house, people who are disabled by apparently unaccountable misery, and so on. This drug-centred approach to evaluating psychopharmaceuticals would be a more accurate reflection of what is known (and not known) about their action,[19] but it would also require significant changes to the regulatory framework away from a disease-centred approach. Perhaps a test of the extent to which conspiring interests are or are not at work might be the readiness to embrace such changes among those who would be involved were they to be proposed.

Psychopharmacology is a Cutting-edge Clinical Science

The second set of implications arising from a critical appraisal of psychopharmacology is that the use of psychiatric medicines cannot be considered as scientifically derived solutions to clients' difficulties. Psychiatric medicines are more accurately thought of as a box of tools available for use in bespoke ways as part of a more comprehensive plan. This is how many psychiatrists see them, but the disease-centred approach mandated by regulatory authorities and, as a result, promulgated by the pharmaceutical industry, presents a different picture. This is prominently on display in the form of advertising and other forms of publicity. There is a huge premium on the sale of new pharmaceuticals.[20] As a result, prescribers are continuously inundated by glossy features and other promotions in the medical press. Where it is

[19] See Moncrieff (2009), especially pp. 14–25.

[20] In most jurisdictions, including the USA and Europe, pharmaceutical companies are able to patent innovations. These rights confer a monopoly market and generally run for several years after a new product has entered it. Thus, there are clear financial benefits to introducing a new treatment for a given conditions every few years, and although these are usually presented as significant improvements in what is already available, the uncertainties associated with psychopharmacology are such that such claims have to be considered with healthy scepticism. This is not easy for the nonspecialist.

permitted,[21] direct-to-consumer advertising makes such material available to the wider public. Advertising and other forms of commercial promotion are skilful and effective enterprises, and so those exposed to psychopharmaceutical advertising are likely to be influenced. On the whole, messages received by potential prescribers tend to be along the lines of 'You know that your patients with (schizophrenia/bipolar disorder/depression or whatever licensed use of the drug might be) suffer. Here is a scientific breakthrough that will revolutionise their lives'. Doctors are brought up on a diet enriched by the possibility of scientific breakthroughs that will revolutionise their patients' lives, and most are in the job because they want to help people. Combined with a graphic image as many such advertisements are, the communication is compelling and the result is a doctor who feels obliged to prescribe the new treatment. Medicine's public is also very susceptible to the charm of a scientific medical breakthrough and therefore generally form a receptive audience readily encouraged to ask their doctor to prescribe the new medicine in response to publicity that has been carefully designed to influence them in that way.

Medicine is very hierarchical profession, which generally pays considerable respect to the renowned professor. Such a person is likely to have acquired their reputation through successful research, which marks them as a beacon of knowledge in their field. This is the basis of their professional esteem. Doctors have an obligation to keep up to date so that the treatments they recommend are as good as they can be, and so an expert in the field is a voice to be listened to. A considerable proportion of psychiatric research is psychopharmaceutical,[22] and so those viewed as prominent leaders of the profession have tended to be those primarily versed in psychopharmacology. For several decades the communicated impression has been that if one is to be an up-to-date, cutting-edge psychiatrist, then what you will be up to date on is psychopharmacology. Many practising psychiatrists do see through this, but some choose not to. More importantly, generalists who, understandably, have less time

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[21] Some countries, notably the USA and New Zealand, permit the advertising of pharmaceuticals in ways that target and are accessed by potential recipients. Others restrict the advertising of prescription-only medicines to forms and forums more usually accessed by prescribing doctors.

[22] Research funding is clearly an issue here and many argue that the pharmaceutical industry invests considerably in supporting medical academics whose work will support their interests. That in itself is a separate debate but there is no doubt that the bulk of funded psychiatric research over the last 50 years has concerned drug treatments.

to consider such messages thoughtfully may take commercially driven messages at face value. For many of them the speciality of psychiatry is expertise in psychopharmacology. As a result, they refer patients to the psychiatrist specifically for assistance with a drug treatment that isn't proving effective in much the same way as they might refer to a cardiologist or gastroenterologist. This is illustrated by several of the vignettes in Chapter 6, which can be read as: 'I am asking for your expert opinion here because difficulties are continuing despite the fact that I have prescribed x, y or z'. When such referrals are made the client is likely to be given the message 'I am asking Dr. A to see you, to see if they can prescribe something that will help you better than the medicines I know about'. The client's view, that it is all about finding the right medication will be reinforced. In fact, there is no clear scientific justification for changing from one antidepressant to another, or from one antipsychotic to another. There is general agreement that from a formal clinical trials point of view there is no difference in effectiveness between the several widely used antidepressants or between the several widely used antipsychotic agents. Clients do differ in how they experience them, and one of the important determinants of those differences is the context within which they are prescribed. Prescription by an apparently expert specialist is a powerful intervention in its own right, irrespective of the pharmacology involved.

There is More to a Prescription than Pharmacology

Although psychiatric medicines don't correct chemical imbalances that can explain mental health difficulties, many clients and practitioners still swear by them and their use continues to grow. It is not too difficult to understand this if the so-called 'placebo' effect is taken seriously. There is no doubt that the way in which any medical treatment is presented to the patient can have a substantial effect upon how they respond to it. This is embarrassing to those who are intent upon limiting their understanding of medical treatments to a linear, scientific view of 'this treatment (commonly but not necessarily a drug) has these properties, which will have these effects upon bodily tissues and mechanisms, and any benefit that might follow can be explained in these terms'. The very existence of the placebo effect challenges the naivety of such thinking, asserts the importance of respecting limits to our knowledge of how the human being functions and emphasises the need to think more broadly when considering what a treatment might do. The so-called naloxone experiment demonstrates that it is mistaken

to dismiss the placebo effect as other than 'real',[23] and investigations exploring how sensitive it can be to a variety of influences, such as the colour of the pills in question, emphasise how psychologically sophisticated it is. Placebo research is beginning to uncover a rich interplay between suggestion, expectancy, past experiences of treatment, desire to benefit and emotional state upon responses to a wide variety of treatments for a wide variety of conditions (see, e.g., Price et al., 2008). The size of these effects is often quite significant,[24] and although they may be difficult to explain in simple scientific terms, it is wrong and unhelpful to ignore the significant role they may be playing. When psychiatric medicines are used in the treatment of mental health difficulties the potential for a wide range of indirect and complex effects may be even greater. Mental health difficulties are emotionally heated, often with intense feelings about the search for relief. However, this might not be straightforward. There is the potential for an infinite range of expectations, past experiences of treatment and hopes for benefit not only in the client themselves, but also amongst their associates and on the part of the prescriber. Every prescription is a singular, meaningful event, and the meaning it carries can be expected to have a direct effect upon the client's response to it. There are huge practical implications to this. No prescriber can say with full confidence that any psychopharmacological treatment will be effective and free from unpleasant effects, and most recipients of a prescription will be aware of that. All any prescriber can say with certainty is that this, that or another medicine *may* be helpful. If they wish it, clients might be better invited to *try* a medical treatment in order to discover for themselves whether it helps or not. The combination of pharmacological uncertainty inherent in all psychiatric drug treatments and the more complex but equally real effects of expectancy and past experiences make it impossible for anyone to predict what will happen with any accuracy. The expectations of clients' associates will be relevant. Of course, there are occasions when someone has to be sedated because they are behaving dangerously or in a very disruptive manner, but how many young people are caused to take medicines because they are disruptive in school or at home, and to what extent is the experience of this as helpful more a reflection of parents' and teachers' expectations than it is of any understandably useful change

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[23] See note 15, Chapter 4.

[24] Vase et al. (2002) reviewed placebo effects in clinical analgesic trials, and more formal studies of placebo analgesia found a mean effect size (Cohen's *d*) amongst the latter of 0.95.

in brain chemistry? How often are people who are taking long-term antipsychotic medicines agreeing to do so because they have come to believe that visits by the nurse, help with their social services benefits and other forms of support are contingent upon them doing so? A prescription may not be what the client is actually looking for but they may find it difficult to articulate what that is. A common concern is the offer of an antidepressant to someone who is emotionally troubled, rather than the prescriber making an effort to understand what it is that is troubling them. In contrast to the client who's search for help is fulfilled by a doctor taking them sufficiently seriously to prescribe, someone seeking real understanding of their difficulties may well be disappointed by a prescription and much less likely to benefit from it. When 'not getting better' is understood as 'treatment failure' this often leads to another antidepressant, and then a third, and so on. Given that we don't know what these medicines do and that we have no firm evidence that any one is any more effective than another, someone's failure to improve or the experience of unpleasant effects is just as likely to be 'this isn't what I want you to be doing for me' than it is a failure to press the right psychopharmacological buttons. Uncertainties about what they actually do and the potential for significant contributions to the effects of prescribing from clients' expectations and other aspects of how they understand it insist that writing a prescription is not just a way of getting a chemical into the patient's body, but an aspect, and only one, of the doctor's fuller relationship with them as a supportive and healing presence.

As a *post script*, mention also has to be made of the part so-called placebo effects may have played and may be continuing to play in psychopharmaceutical drug trials. These provide data that are the formal justification for licensing and skilful marketing. Many subjects providing these data are aware of whether they are taking the active agent or an 'inert' placebo.[25] Given the effects of expectancy and other influences lumped together under 'the placebo effect' this amounts to a methodologically unsatisfactory experiment. An important set of variables has not been controlled, and their effects could explain drug/'placebo' differences, irrespective of the drug's chemical properties. As a result, practically all of the data upon which psychopharmacology bases its claims for efficacy are flawed. Once again, this is not the place to consider conspiracy theories about how the psychopharmacology industry

[25] Notes 24 and 25, Chapter 4.

has grown and profited in recent decades. That is done perfectly well elsewhere,[26] but the fact that the evidence is seriously flawed has to inform practitioners and public. Practitioners have a responsibility to ensure that their interventions are minimally harmful, and often that involves weighing up evidence for efficacy against knowledge of potential harm. If the evidence for efficacy is actually much less sound than the publicity suggests, this balance is shifted. There may well be clients who clearly want to try a medical treatment for their difficulties, but there is a professional obligation to ensure that this is a fully informed choice, and that information should include doubt about the medicine's reputation for efficacy. Other clients may come openly seeking information about medicines' usefulness in the treatment of mental health difficulties. The practitioner who does not make it clear that in truth little is known, and instead firmly recommends this, that or a third psychopharmaceutical as an established remedy could be considered to be in breach of their professional standards. It is a credit to the marketing skills of the psychopharmacology industry that a great number of practitioners could well fall into this category.

Therapeutic Gains Attributable to Mental Health Professionals are Largely a Result of the Helpful and Supportive Relationships they Develop with their Clientele

In many ways the helpful and supportive relationships developed by mental health professionals with their clientele are the most helpful finding from the half-century experiment. Rather than concluding with what psychiatry isn't, or can't be, this return to the importance of relationship in healing and helping suggests a way forward. It is radical and challenging because, on the face of it, it suggests that there is no place for psychiatry's grand enterprise. One could conclude, as some do (Burstow et al., 2014), that psychiatry should be abolished, and all that is needed is for people to be nicer to one another. If only it were so simple.

The research findings are that most adult mental health problems can be traced to difficulties in early life. Most agree with this; indeed, this is the essence of Sigmund Freud's theorising. Contemporary and more scientific data supporting this can be found in the forms of clinical studies, clinical epidemiology, secondary analysis of birth cohort data and

[26] Note 9, Chapter 4.

cross-sectional surveys.[27] There is also evidence that much could be done about this, but sadly the work involved doesn't attract a high enough priority.[28] Although bringing new people into the world is something most people do, and do perfectly satisfactorily, for a significant minority the process is unsatisfactory and the result is a young person who is vulnerable and has difficulty relating to others in one way or another. Bad things happen during adult life, which can be traumatising, and not everyone negotiates a traumatic experience successfully. Some are left suspicious, dependent upon drugs or alcohol, frightened or withdrawn. Growth into an adult human being and life as one are not always straightforward, and those for whom it isn't are those who are at risk of behaving in ways that disturb others and, as a result, becoming identified as someone with a mental health problem. It may be reasonable to argue that describing such people as 'sick' is a flawed approach, but that, in itself, doesn't negate the fact that humankind includes a significant minority of individuals who have grown into or have become people who don't get on with others and, as a result, are failing to thrive. The overarching experience of the psychotherapies is that people who have difficulties relating to others, sharing a common reality, facing fears or feeling comfortable with themselves can be helped, and that doing so is largely achieved in the form and through the medium of a helping and supportive relationship. If society is to respond humanely to those who are in such difficulties then all the evidence points towards that

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[27] These data are summarised by Peter Jones (2013). Half of all who subsequently become identified as someone with a mental health difficulty will have suffered in some way by the age of 14 years. This ranges from 11 years as the age when half of all anxiety disorders might have begun to 30 years for the same assessment of mood disorders. These findings can be discussed in terms of with what is known about human brain development through childhood, puberty and adolescence, as Jones does, but there is no evidential or epistemological justification for privileging this causative connection over explanations based upon emotional well-being and appropriate parental nurture.

[28] Patrick McGorry (2013), an Australian proponent, champions 'early intervention' as an institutional approach to the risks of longer-term difficulties amongst troubled young people, but, at the same time, draws attention to the inescapably harmful labelling that comes with this. Paul Stallard and Rhiannon Buck (2013) describe how it is quite realistic to include a resilience-promoting programme in the school curriculum and reduce the risk of 'depression'. Andrew Chanen and Louise McCutcheon (2013) discuss ways in which earlier intervention amongst younger, more vulnerable individuals might mitigate the development of distressing patterns of interaction which are conventionally known as borderline personality disorder.

being best achieved by making helping and supportive relationships available. That is not easy. Illustrative referral letters show how it is that when someone becomes identified as one suffering a mental health difficulty this is generally because relationships have broken down, and those associated with the client have become desperate or have lost patience. The situation may even be one in which common wisdom dictates a need to sedate and control for a period of time; not the best beginning if a mutually trusting relationship is the goal. The lessons of history are that humanity has always and quite possibly always will include some who have difficulty living amongst others. Lessons of the last half century's approach to this are that attempts to view and treat them in the way doctors view and treat diseases are flawed, but they also teach that patience, understanding and empathy that result in a mutual and trusting relationship can be transforming.

This takes time and commitment. It is enabled by skills that can only come from the experience of spending time with those who see the world differently. It has to be conducted on the client's terms. For many, a medical treatment is seen to be the solution and where that is the case, denying it would be as unhelpful as insisting upon it when it isn't sought. It has to be conducted with respect for external boundaries. A sexual relationship between a client and their healthcare practitioner would be frowned upon, could only be conducted covertly and, as a result, it would undermine rather than support mutuality. Others' safety and respect for wider perceptions of acceptability mean that coercion may be necessary, not in order to 'treat' severe 'illness', but to protect the client from worsening the situation they have already fallen into. All of these require resources and training, some of it medical insofar as drug treatments may be called upon. Finally, when circumstances require it, psychiatry does need the authority to act on the client's behalf if not on their wishes, but all of these are unlikely to be either effective or justified if they aren't seen as elements of a set of processes designed, centrally, to reach out and relate to marginalised, misunderstood and frequently confused human beings and those affected by them, rather than merely trying to 'treat' them.

Afterword

So far, little has been said about psychiatry's more public controversies: legislation that legitimises detention and treatment without consent; supervision orders; invasive physical treatments such as electroconvulsive therapy (ECT) and psychosurgery; and secure settings that house and treat mentally disordered offenders. That is because, although all of these do raise questions about the relationship between psychiatry and human rights, these questions are more helpfully considered from a wider perspective. Historically, contemporary psychiatry has grown out of practices and provision around people found to be causing inconvenience to others, and it was commonly brutal and coercive.[1] When an attempt is made to answer the question 'What does psychiatry do?' the answer seems to be 'Address situations where a distressed, disturbed or confused person is disrupting social order'.[2] From this point of view psychiatry's more notorious practices are not somewhat dodgy add-ons that it sometimes does for questionable reasons or under particular duress. They are extensions of what it is does all the time into situations where, for one reason or another, it has to be done in a coercive, restrictive or even apparently brutal way.

It is very difficult to envisage a time when there might be so small a possibility of disturbed, confused or distressed people acting in a dangerous manner that there would be no need to anticipate it. Mental health legislation of one form or another is to be found in all contemporary jurisdictions, and legislation governing provision for 'the mad' can be found in early European legislative codes, from medieval

[1] See historical references in Chapter 7, especially Michel Foucault.

[2] See the illustrative referral letters making up the body of Chapter 6 and the sections concerning reactions to distress and social order in Chapter 7.

times onward. The need for legislation that both permits and governs the paternalistic use of force in situations where the perpetrator of dangerous or anxiety-provoking behaviour is considered deranged in some way is generally felt to be beyond debate. What might be under discussion and therefore fuel controversy is the form that might take: under whose authority it is exercised, what sanctions it might permit, whether such sanctions can be extended into a person's home life, for how long they might operate and under what circumstances they might come into effect. How these questions are addressed and answered in any one jurisdiction is for discussion elsewhere, and particularly within the context of that jurisdiction. What all such conversations will have to conclude, however, is that it is impossible to rule out the need to permit lawful coercive and paternalistic actions against others in the interests of apparently compassionate humanity. Individuals could be left to jump off bridges or poison themselves, run naked through town, die from exposure, attack others in a frenzied manner, or behave in a legion of other personally self-destructive or threatening ways, but common compassion and the need to maintain social order insist that there must be lawful access to action in response to them, even if it involves the use of coercive force. Controversies are not over whether or not such powers should be available at all, but over the forms they might take and the circumstances under which they might be exercised.

Similar arguments apply in relation to invasive physical treatments. There is no clear understanding of what happens, therapeutically, when a person undergoes ECT, and there are no conclusive and convincing clinical trial data supporting its efficacy.[3] Nevertheless, many practitioners have seen clients recover quite dramatically following a course of ECT after, perhaps, many weeks of not improving with other forms of therapy. Likewise, there are patients who suffer recurring episodes of profound psychological disability who themselves have previously found ECT to be an effective way of bringing it to an end, and explicitly, clearly and in an informed manner, request ECT. There are situations in which desperate relatives and other associates plead for 'something' to be done when all else seems to be failing. The now very occasional resort to psychosurgery can only happen with the consent of patients

[3] See UK national guidance on the use of ECT (National Institute for Health and Clinical Excellence, 2009).

and others.[4] It does continue to be used, but in very exceptional circumstances. When ECT or psychosurgery are used, on the whole, it is because 'desperate times have called for desperate measures'. If and when they are effective there is no full, clear and generally agreed understanding of why that has happened, and the decision to use them is almost always driven by the fact that all else has failed and a very distressing set of circumstances will continue unless 'something is done'. It may well be that certain contexts; practitioners, jurisdictions, healthcare providers or traditions of practice are readier to resort to ECT than others, and it could well be that these are justifiable grounds for concern over the quality of care available in such situations. However, it would be a bold jurisdiction that decreed there could never be a situation in which it a desperate person or those associated with them had access to it, and insist that it's use is invariably inhumane. Realistic moral debate, surely, revolves not around 'whether or not', but 'when and under what authority'.

It is equally unrealistic or utopian to envisage a world entirely devoid of dangerous, devious, violent or destructive individuals, or a situation in which the very existence of such people doesn't raise fear and concerns. Clearly, much might be gained from a better understanding of how such persons come into being and how that might be prevented, but emotional abuse in childhood, psychological trauma and other likely contenders are yet to be effectively addressed as public health issues. The harsh reality is that there are people who might well harm others if at liberty to do so and it is understandable that any community might want to protect itself from them. Again, the question is not the rights and wrongs of doing so at all, but 'when and under what authority?' It could well be argued that our so-called risk society has become too preoccupied with attempting to influence the future by controlling

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[4] Psychosurgery is the surgical interruption of certain neuronal pathways in the human brain with a view to alleviating distressing psychological disorder. A crude version, prefrontal leucotomy, was carried out quite widely for a period during the 1940s and 1950s. Contemporary psychosurgery involves much more precisely located interruptions of neuronal pathways and, when carried out, it is now in response to seriously disabling obsessional disorder, depression or anxiety. In England and Wales psychosurgery is only permissible with the patient's consent, and this itself has to be established by a panel of three that includes legal, psychiatric and lay perspectives. Scottish law does allow psychosurgery upon nonconsenting persons provided they can be shown to lack mental capacity and a Court of Sessions approves, but this power has not been used since it became available in 2003. Over the last 30 years the total number of annual instances of psychosurgery throughout the UK has been confined to single figures, and it is a rarely used intervention elsewhere.

the present but there exist, for instance, individuals born with congenital brain damage or victims of head injury whose behaviour is so intractably threatening and destructive that in earlier times they might well have become victims of vigilantes or a lynch mob.[5] Indefinitely housing such people in a secure setting might not be the best expression of human rights but it might be the more compassionate option. Once again, the question is not 'Whether?' but 'When?'

Although the Universal Declaration of Human Rights promotes the right to liberty and security,[6] legislators have found it necessary to set limits upon this in order to accommodate possibilities that might result in unacceptable disturbances of social order. In the case of the British Human Rights Act (1998), these include the detention of persons convicted by a competent court and in circumstances where there are reasonable grounds to believe an offence might be committed or there is a need to oblige a person to answer charges of committing an offence. They also include the need to detain someone 'for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants'.[7] In other words, although the utopian vision of universal human rights might have considerable merit and attractions, its expression in enforceable law demands reservations. These are entirely understandable and largely noncontroversial in relation to criminality. Their extension into areas where social order might be challenged by noncriminal activities such as the spread of infectious disease or the behaviours of persons 'of unsound mind' is a reminder that even the notion of universal human rights has to be predicated upon the prior maintenance of basic social order.

Given the weakness of the case that mental health difficulties as a whole can be sufficiently understood as diseases clearly understood by medical knowledge and best provided for by medical treatment, and strength of the case that they are better understood as threats to social order, it is easy to understand their ability to elicit organised reactions that extend beyond the capabilities of medical science. Thus, people are detained, sedated without consent, subject to supervision orders, offered invasive treatments and even incarcerated for long periods not because it is clearly known that doing so will 'treat' an underlying medical illness, but because the situation is such that not doing so will result

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[5] A reference to Ulrich Beck's *Risk Society: Towards a New Modernity* (1992), and Giddens' 'Risk and Responsibility' (1999).

[6] Adopted by the United Nations General Assembly on 10 December 1948.

[7] Article 5, clause 1 (e).

in a serious disturbance of social order. This is not of itself an unjustified abuse of human rights. From many points of view, when one or more of these things happens it is plain common sense, as legislators have had to acknowledge when turning the utopian vision of universal human rights into statute. In the real world there are limits to what can be accommodated if society is to function as a means by which all can enjoy the benefits of civilisation.

Mental health difficulties, how they are defined and how they are responded to all draw attention to those limits and needs to acknowledge and address them. Contemporary society is one in which technology has provided ready solutions to a wide range of difficulties: food shortages, clothing, shelter, warmth, transport and communication. Technical developments have also made medicine a more effective bulwark against disease and bodily degeneration, and it is understandable how and why it has been an attractive place to go to for solutions to difficulties in human relations. Human relationships are not always straightforward and harmonious. If they are to include formative processes such as the emotional environment in which young people become adults, reactions to trauma, exploitation and other adversities then the concept of unhelpful and damaging relationships acquires meaning. How well we care for our young and accommodate our contemporaries' needs are powerful determinants of whether or not the result is a community of human beings voluntarily living together in relative harmony, or one riven by strife and adversity. It has been attractive to imagine that misery, social withdrawal, confusion, anger, betrayals of trust and other social shortcomings are no more than difficulties readily fixed by a bit of psychotechnology, whether that be a medicine or a programme of corrective therapy. The evidence is that this is a blind alley and pursuit of a better society should head elsewhere.

For the practitioner or the curious student, a nonmedical, more socially oriented approach to mental health difficulties has a number of implications and attractions. Firstly, it encourages those who, to paraphrase Sir Denis Hill (1960), do not want to be shielded from awareness of the patient. It provides a firm basis from which to explore medical practice as a social endeavour, with all the intellectual and practical implications that come with that. Secondly, it reasserts the practitioner as an active participant in institutional life. The ability to frame clients' difficulties as more than just abnormalities within them and awaiting treatment, but as difficulties negotiating, expressing or making sense of

their circumstances draws attention to those circumstances.[8] Are institutional arrangements that offer 'evidence-based' medical treatments or managed packages of care truly the best ways of achieving these ends? To what extent should the practitioner collude with a client's attractions to the sick role? What sort of research really advances our understanding of medical practice, and how might it takes a form that be better funded if it takes a form that doesn't immediately point towards economic efficiency?

There will probably be as many other suggestions as there are people who choose to consider these questions, but the most compelling has to be that this is the direction to follow if we are to pay proper attention to what our clientele are telling us works for them.

[8] An approach to mental health difficulties that adopts this perspective and is growing in popularity, is so-called 'open dialogue'. Rather than simply setting out to 'treat' an individual, practitioners, generally operating as a multidisciplinary team, set out to understand and ameliorate, in conjunction with all involved, the social disturbance that has developed around the individual and their difficulties. The approach has proved remarkably successful amongst even quite disturbed 'psychotic' 'cases' (Seikkula et al., 2006).

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