Annotated bibliography and book reviews

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This is work in progress. Over the past year I have been undertaking an extensive literature review related to voice hearing. One of the products of this work has been to produce this annotated bibliography that I will make available to students. I will update it from time to time.

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This paper reviews the implementation of a pilot scheme, the main principles of which are described as:

1. The therapeutic activities are planned and carried out flexibly and individually in each case so that they meet the real and changing needs of the patients as well as of their family members.
2. Examination and treatment are dominated by a psychotherapeutic attitude.
3. The different therapeutic activities should support and not impair each other.
4. The process quality of therapy is clearly perceived. A family-centred initiation of the treatment is especially emphasized for both diagnostic and therapeutic reasons.

(p. 363)

The *Finnish Need-Adapter Approach* is a psychotherapeutic approach which is tailored for each individual. It is based on the premise that the Kraepelinian view of schizophrenia is not proven.


Paper about the different types of hallucinations being experienced by deaf people. It involved a factor analysis of responses from deaf voice hearers to 94 questions. Five groups emerged:

A. Nonauditory voices with subvisual perception of voice articulators in the mind’s eye.
B. Mixed perception and uncertainty about how voices are perceived.
C. Poorly defined voices.
D. Auditory voices.
E. Voices and true visual, olfactory, gustatory and tactile phenomena.

Results do not contradict earlier findings, but help clarify what people may be experiencing.

Emphasis on need to be clear about what deaf people mean and to be wary of straight BSL-English translation.

Some discussion of sub-vocalisation and whether some similar process is occurring, but with deaf language production. This discussion is linked to developing an ‘*articulatory model of voice-hallucinations in deaf people*’ and includes issues to do with the nature of visual hallucinations being associated with communication rather than being a true visual hallucination.

Magazine articles, but quite useful for the analogy to the Emperor’s New Clothes.

Short résumé of Italian psychiatric system as compared to other countries, including the UK. Interesting data such as Italy having 6.4 social workers per 100,000 pop. as compared to 58 in UK.

This study uses client and family narratives to form a 4 stage model of developing psychosis:

1. before the first psychotic episode
2. the first psychotic episode
3. first hospital admission
4. current experiences

It is also an illustration how professional understandings can restrict listening. The study could be criticised as not valuing the understanding of those whose narratives it uses as it is bound by a professional knowledge which leads to the stages above.

Paper examines social exclusion including the impact of social work services on service users when respect is lacking. The author argues that lack of respect compounds the trauma that may have resulted from childhood abuse. She also describes how this is similar to PTSD symptoms.

This is a rare mention within social work literature of the importance of considering trauma and abuse in respect of psychosis.

Response to the potential stigmatization of mental disorder in Stroud and Pritchard’s paper on child homicide. Raises criticism of diagnoses based on Bentall’s work which criticises the Kraepelinian construct.

Large scale structured survey yielding statistical data on the correlation between certain lifetime events deemed intrusive and experience of mental ill-health. Discusses vulnerability, susceptibility, mood and victimisation. Some useful numerical data regarding some traumatic events. Some useful discussion of the meaning of that data in relation to trauma.

Bentall’s arguments focus on the lack of validity to the Kraepelinian construct of schizophrenia. He sees this as a paradigm of thinking about psychological differences and proposes that a complaint focussed paradigm should replace it. What also distinguishes Bentall’s work is that it is based on scientific research. He acknowledges individual narratives in his choice of ‘complaint’ rather than ‘symptom’ for the proposed paradigm, but his arguments are heavily scientific.

He argues that the Kraepelinian paradigm became fully entrenched through the DSM3, but he argues that the trials accompanying DSM3 showed no evidence to support the models that the APA adopted. He refers to this as ‘psychiatric folklore institutionalised by committee’ (p. 222). In particular he makes arguments
about co-occurrence where patients with one disorder exhibit symptoms from another. The only argument possible in the Kraepelinian paradigm is that patients with one illness become more susceptible to a second, whereas Bentall argues that ‘the real reason why patients meet the criteria for more than one diagnoses is that the diagnoses do not correspond to discrete psychiatric disorders after all’ (p. 223).

Bentall argues that we should abandon diagnoses and focus on complaints, especially auditory hallucinations and delusional beliefs. His evidence is strongly biological, arguing for example that voices can be explained in terms of subvocalisation and problems in relation to source-monitoring while delusions may be linked to poor social and psychological functions, e.g. externalising fault.

Bentall also argues the importance of heeding the studies that show a link to trauma even if these are retrospective.

Concludes by discussing the value of CBT, but mainly for the need to develop treatments from a different paradigmatic perspective.


Quite a useful paper for understanding the distinction between public and self stigma. This seems to be similar to ideas of internalised oppression. The paper is concerned with the impact of diagnosis on stigma


Interesting paper about the relationship between the Human Rights Act and the Mental Health Act.


According to Bentall (2009) this paper began as a comparison of medication and psychotherapy for psychosis, but as Bola could only find 6 studies that met the criteria for inclusion, it was rejected by several journals for not including enough studies. The point of course was that there were only 6 that could be included, but given that Bola was criticising the need for medication and the pharmaceutical companies have so much control over the psychiatric profession, he had to change the focus of his paper and rewrote it as an ethics paper to gain publication.


Loren Mosher’s Soteria House project which ran from 1971 to 1983 is one of the best examples of treating people for first psychotic episodes with no or minimal medication. Mosher staffed the house with unqualified and inexperienced people, mainly students, who offered social support. The experiment has led to a Soteria Movement and there are many papers evaluating it – this is a good starting point.


This paper describes differences between personal, social and natural concepts of illness.

I think that contrasting personal versus either social or natural concepts of illness makes it possible to argue that psychiatry, like homeopathy or shamanism, should be a matter of individual choice and that compulsion takes away choice of belief about health.


This paper discusses the origins of critical psychiatry and proposes that Post Psychiatry is capable of opening up spaces for new ways of thinking as opposed to anti psychiatry which wanted to propose an entirely different understanding of madness. Very succinct and useful paper.

One question that is worth considering is whether post psychiatry would actually retain too much of the existing psychiatry and help prevent a new paradigm from emerging?

Very brief quotes from some deaf people with psychosis, from which the author concludes that deaf people should be believed. Focus on not understanding how deaf people can hear rather than on how non-deaf people impose meanings on deaf people.


Good introduction to the 1978 reform and why the 1994 Mental Health plan was needed to ensure adequate services were funded and provided. Some useful quantitative data alongside a good account of the change. Positive ending with claim that Italy has been able to demonstrate over 25 years that it is possible to do away with institutions and provide community based services.


Interesting review of ASWs and their roles. New challenges to coercion are seen in terms of the debates about the value of Community Treatment Orders and in terms of service user dissatisfaction with detention, but no real detail about why this might be. Made me think about the Danish HVN which is conducting an investigation into the deaths in care related to drug overdoses, but which are formally recorded as unexplained.


This paper refers to the 1980s and early 90s as a period of optimism re community care, while more recently the atmosphere is one of fear for public safety. Q. Does this reflect a professional response to consumerism – to control people's choices by breeding fear in others?

Paper refers to coercion and 'compliance or adherence' which are terms used elsewhere in medicine and are commonly used to explain failure through blaming patients.

The authors accept a need for coercion if someone is incapable of making decisions or if they present high risk to self or others, but there is no question about the efficacy of what someone might be coerced into.


This paper reviews changes to community treatment in Canada, Australia and UK. The focus of discussion is on the need to clarify the roles of social workers and to debate the changes in relation to ethics of practice. The authors have a restricted view of ethics concerning coercion and discuss the need for control.


Study undertaken to explore issues concerning nurses changing paradigms and working with voice hearers by talking about the content and meaning of voices. Voice hearers reported this would be useful and nurses recognised that changes were taking place, although this was different to how they were trained. Sharing experiences was important to most voice hearers. Nurses felt lacking in skills and confidence.

Interesting study with many parallels for social work.


Discussion about pseudohallucinations (internal source) and true hallucinations (external source). These terms are criticised for the value judgements they make and for their lack of empirical validity and having no clinical significance. Also the term pseudohallucinations has two meanings, *one based on location in internal, “subjective”, space, and the other based on the patient’s recognition that the percept has “no correlate in
the external world”, which might broadly be construed as insight. Most psychiatric texts have adopted the former meaning of pseudohallucination.(2)

Although the papers referred to in this are medical and therefore difficult to understand by non-medical readers, the potential value of this paper is in showing just how much focus is being put on papers which appear to be pursuing a failing route of research.

This study shows the value of intensive psychosocial support for people with a first psychotic episode, similar outcomes to Soteria project (see Bola and Mosher, 2003). It is within a Kraepelinian paradigm as it is about treating people diagnosed with schizophrenia. The team used 2 approaches, the Finnish need-adapted treatment approach and the Soteria low stimulus crisis centred model. Need to find out more about both of these.

Most of the focus of this paper is on the process of ASW work, rather than the politics of that work.

A study of some interest. It was conducted by 2 service users under direction of an academic. The main findings relate to the type of feelings related to stigma. The researchers interviewed people without using the term stigma so as not to lead respondents.

Introductory article explaining the HVN and what it does, including its mission statement. Useful as an authoritative reference point on HVN.

Good review of the literature about deaf people hearing voices and some useful examination of the nature of the voices that a sample of deaf people hear. Concludes that the results counter the view that deaf people cannot hear voices unless it was later onset. Paper doesn't address the issues raised later by Paijams et al regarding the imposition of a hearing world on our understanding of ‘auditory hallucinations’ in deaf people. One important point to note is that psychosis and hallucinations were found to be as frequent in deaf people as others.

Elbogen, E. and Johnson, S. (2009) The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions, *Arch Gen Psychiatry*, 66(2) 152-161.
Large scale US survey which concludes that the only mental health factor that shows any significant correlation with violence is drug/alcohol dependency. Mental health cannot predict violence.

Brief paper describing survey of GPs in North East and North West regarding their prescribing practice of psychotropic medicine to children with learning difficulties. Most seemed to be quite happy with their knowledge vis-à-vis ADHD. Quite telling how accepting the use of psychotropic medicine with children was. This survey was aimed at finding out if the GPs needed more training, not at the impact on children.

Good prevalence and risk data on children hearing voices. Auditory hallucinations in children were found to be related to: schizophrenia; anxiety and depression; migraine; trauma, dissociation process and reactive psychoses; deprivation; reaction to grieving. There is also a useful commentary on different cultural understandings of voices.

The researchers describe different approaches to understanding voice hearing:

- Biological psychiatry – the voices have no meaning
- Cognitive model – voices related to the absence of reality testing
- Psychoanalytic theory – related to either the under-development of the ego or to regression at an earlier stage of development
- Social-psychodynamic approach – voices as a means of coping with life events or as a defence mechanism developed as a reaction to trauma.

There were some good elements of care that were found helpful by children, parents and/or the research team. Also some interesting and useful practice issues are discussed.

Voice hearing was found to be related to trauma in 75% of children. These traumas included:

- Grief, particularly if protected from
- Problems at home – space, relationships, moving, divorce
- Problems at school – bullying or learning problems
- Abuse, birth trauma and disability


As the title suggests this is a survey of ASWs in respect of their training needs. One interesting point in this was the use of the phrase 'to manage patients'. The discourse being used in ASW related research appears to suggest that patients need professionals to manage their lives.


Whilst this paper is concerned with conflicts between current policy and community capacity building, the focus on 'the provision of a clinically orientated evidence base for practice and the need to contain 'risk'' has much in common with the critique of Kraepelinian constructions of psychosis.


Reiterates the impact of 'alienness' and a belief in a genetic basis of schizophrenia leads to the over-diagnosis of Afro-Caribbean Britons. Without consideration of the social and political context of mental health the DSM proposals will lead to loss of human rights of young black people.

Fernando doesn't appear to deal with the question of whether racism might be a causal factor of psychosis.


Important paper that counters claims that the reporting of childhood sexual abuse by psychotic patients should be treated as delusional. Interesting to ask if the rejection of such reports by psychiatrists is delusional on their behalf?

Brief editorial to APA journal calling for inclusion of patients’ subjective experiences in the construction of DSM-5. However, rather than being radical, this is more about expanding the types of evidence used in the DSM. Hence they say "a sense of self as impaired" could be reliably and accurately diagnosed as "an impaired sense of self" (p. 391).


Interesting that the JSWP should have papers on self-directed support as this seems to be marginalised in some ways as administrative, not psychosocial. This is a study of social work staff and their attitudes so I suppose that could be the psychodynamic element?


Discussion by a service user researcher about the dilemmas she feels about imposing her own meaning of recovery on others.


First person account of being diagnosed schizophrenic while in US military, getting and losing jobs, but eventually finding security and less stigma in psychology industry.


Brief article from someone expressing her fear of telling others she has been diagnosed with schizophrenia.


Arguments for CTOs seem to centre on compliance with treatment. Effect on readmission rates seem to vary. One of the main benefits is improved access to services, but presumably this means access was experienced as poorer when not under a CTO. This reflects the practice of mental health professional in relation to non-coerced service users.


Focus of this paper is on the care experiences of people in hospital, but not their medical treatment. Lots of issues around safety and comfort are discussed which is of course important, but it does not consider issues such as choice and involvement in treatment.


Family factors involved prior to onset of schizophrenia thought to include communication deviance and affective style. When high CD combined with negative AS, predictability is suggested to be good. Expressed emotion (EE) thought to play a part in relapse, but this review suggests that this may be more related to when than whether? The key issue would be stopping medication, then families with high EE might contribute to quicker relapse.


Small study which ends up blaming local authority bureaucracy for preventing social workers from properly empowering people? Typical practitioner research which treats the practitioner as infallible.


Paper sets out the basis for using CBT with symptoms of psychosis, but this is in the context of an illness model. This is particularly telling in relation to the vulnerability-stress model which is interpreted quite
differently to Read. The value of CBT seems to be similar to that suggested by Bentall, but the context is different.


Editorial defending a genetic causation of schizophrenia as an introduction to a study that says the opposite. Interesting level of desperation in this defence of genetics.


Introduction to and an authoritative reference point on the Campaign to Abolish the Schizophrenia Label (CASL).


Another introduction to the aims and purpose of CASL.


Paper about the need for psychiatric nurses to be trained to ask about childhood sex abuse. Training would help give them the courage to ask and the expertise to listen. The paper then provides a lot of argument for recognising the link between CSA and psychosis, especially voice hearing. It also gives some useful descriptions of PTSD, dissociation and trauma cascade.

Arguments also apply to social work. Strong case for countering the tendency to ignore psychotic people in research and to disbelieve psychotic patients in practice.


Given the association between childhood sexual abuse and voice hearing in people diagnosed with schizophrenia, this paper investigates if similar links apply with people diagnosed with bipolar disorder. While there was a significant association with general trauma, the significance with CSA was high.

In strengthening the link between CSA and voice hearing, the paper also strengthens the need to view voice hearing as a psychological issue, not part of an illness profile.


In this article we will demonstrate why psychiatry should reconsider its position to ensure more adequate treatment and make it possible for people to recover. We will also report on what we now know about the mental health problems of people given this diagnosis by psychiatry. We will, therefore, cover three main areas: first, a summary of the evidence that leads us to conclude that the disease model of schizophrenia has failed; second, an explanation of why we believe that after a number of historical 'false dawns' a genuine paradigm shift away from the disease model and towards a more coherent account of psychological distress is not just a possibility but is imminent; and finally we will discuss possible alternatives to the schizophrenia diagnosis. (p. 15)

Arguments against the disease model of schizophrenia and a call for a paradigm shift to understanding psychological distress. Useful paper which discusses many issues, for example anti-psychiatry, trauma models and dissociation.

Useful and accessible summary of Kingdon and Turkington’s 4 subgroups of psychosis:

- Sensitivity psychosis
- Anxiety psychosis
- Drug-induced psychosis
- Trauma-induced psychosis

Study of people in Nottingham at first episode psychoses which looked at social class of fathers and level of deprivation in the area their mothers lived at birth. This showed increased risks of schizophrenia due to deprivation at birth and that this might be more an issue for people with later onset of psychosis.


Quite a clinical, though very interesting paper which aims to identify characteristics of patients which would indicate their capacity to manage without anti-psychotic medication. Detailed but not easy to grasp the final conclusions.


Very detailed and important paper in relation to the circumstances and diagnoses of people detained.


This is about subjective illness theory and compliance, not about insight which is itself often defined in terms of compliance to a medical illness theory. Reasons cited by respondents for explaining the onset of their condition:

- 48.4% psychosocial stress – burden, strain, pressure
- 32.1% conditions in childhood – aggression, ill-treatment, identity problems
- 24.3% personality factors – sensitivity, inferiority
- 16.7% genetics
- 14.1% alcohol and drugs.

The researchers relied on self reporting of compliance so as to not discourage cooperation with the research.


*The significance of this study is that it presents evidence that the form of the hallucinations experienced by both patient and nonpatient groups is similar, irrespective of diagnosis.*

Early exploratory study from the Maastricht team with some pertinent data about the types of hallucinations experienced by different people.


Important papers in terms of discussing mental health and the social model, particularly in relation to:

- the distinction between impairment and disability
- the way the social model has left the body and impairment within the domain of medicine and
- the Cartesian distinctions of disability and impairment that mirror the mind-body split in psychiatry.
If the social model needs to recapture the body, then we also need to consider the situation of the mind. On the one hand the Cartesian split in psychiatry (Jaspers) has placed the mind in the body and outside of the environment; on the other the social model has left the body with medicine.

While this paper makes a good case for the social model to engage with the body and with impairment, the attribution of causality between the social model and the medical dominance of impairment is wrong. The social model distinction may need to change, but its purpose has been to take control of disability away from medicine. There is a case that the disabled people’s movement needs to do more and the Hearing Voices Network and CASL may well be a good example of how this is happening.


Workforce study examining the sources of problems for mental health social workers. Some mention of lack of alternatives, but the examples used of assertive outreach or crisis teams are very much part of a biomedical paradigm of practice.


Study of the relationship between assessment and eligibility decisions made by various health and social care staff groups. Substantial study, but little on specific examples of need/eligibility.


Written in response to proposal from the DSM-5 committees to development of a new diagnosis of psychosis risk syndrome. Discusses some problems with introducing a predictive diagnosis, but on balance argues it is worthwhile if it focuses on known risk factors without necessarily associating them with an 'end-stage syndrome'. It also argues that treatments be restricted to those with low impact on false positives.


Quite detailed exploration of the Human Rights Act issues affecting mental health practice, but mainly with a view to the administrative understanding of the implications, rather than the rights of the individual being detained.


Very reflective account of learning about schizophrenia and then by being sceptical, questioning the concept as a disease, but coming down on the side that it is a disease. However, Johnstone doesn’t question whether the symptoms belong together. Useful in terms of discussion of what is a disease.


Starts with a comprehensive introduction to the various ways in which voice hearing has been theorised within psychiatry, psychology and to some extent by voice hearers. Description of the study and discussion of the participants that typified the 6 factors that emerged from analysis of the Q-sort: positive spiritual perspective, personal relevance perspective, resigned pessimist perspective, pragmatic response perspective, passivity to forces perspective, and generic mental illness perspective.


Interesting paper in that it is directed at social workers and their need to have an understanding of the way voices are experienced. Useful way in which Karlsson talks of the need for an integrated language to allow social workers to be able to work more effectively with voice hearers. Detailed discussion of findings, but in many ways the introductory discussion and conclusions are most useful.

Argues that psychosis risk syndrome is a misuse of the term 'risk' as people presenting with the intended criteria are seeking help with real problems, not future ones. Existing category of Psychotic Disorder, Not Otherwise Specified is thought to be sufficient. Also argues that being at risk of schizophrenia is nonsense given the lack of validity of schizophrenia as a diagnosis.


This is an important paper that is often used to defend the Kraepelinian construct on the basis of its utility, despite its lack of validity. The validity of syndrome should be based on clear boundaries between it and other types, or there should be a clear physiological difference.

Utility means that the diagnosis 'provides nontrivial information about prognosis and likely treatment outcomes, and/or testable propositions about biological and social correlates'. Effectively this becomes an argument that because psychiatry has carried on for so long using schizophrenia as a diagnosis, it is useful to carry on.

However I would argue that the utility of realising the limits of the validity of the diagnosis is to justify consideration of an alternative model of psychosis based on useful constructs such as hallucinations which people report as problems.


This paper explores Kraepelin’s work and describes him as a sceptical realist.


This paper discusses the policy and practice implications of moving from a medical to a psychological model of mental health in service provision. It is very much a manifesto with brief description of the implications for various staff groups. Medicine would be targeted at symptoms while social workers would be involved with issues such as poverty and social deprivation. Nurses would undertake psychosocial approaches to care. OTs seem a bit difficult to include beyond work, this paper suggests they are key to a SMOD approach.


Overall argument that Psychosis Risk Syndrome could have beneficial impact on the development of Early Intervention in Psychosis (EIP) services but that it has the potential to increase stigma and inappropriately treat large numbers of people.


Kinney assesses the ethical issues involved in detention against the two criteria for detention:

- the person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital ...; and
- the person ought to be so detained in the interests of their own health or safety or with a view to the protection of others.

In relation to the first of these he questions whether the premise is false, whether the judgement made by a psychiatrist is valid. He believes that challenging the psychiatrist’s diagnosis ‘is in practice mostly futile’ (Kinney 2009:331).

Kinney describes a typical situation in which the AMHP is presented with two medical recommendations and left to arrange the admission. Whilst having 14 days to complete their assessment, the organisational pressure in terms of role, lack of resources and the presence of anxious family members and police officers makes it almost inevitable that admission will follow shortly afterwards. He states that,
Such preventable coercion is possibly one of the biggest under-reported scandals of our time.

(Kinney, 2009:334)


Cochrane review of compulsory OP treatment which concludes that they are ineffective and impossible to target without unnecessarily coercing large numbers of people.


Risk management, rather than best care has become the main role of professionals and this has been accompanied by a move towards a standardised approach to assessing risk.


The four key standards against which the authors argue the proposal of a Psychosis Risk Syndrome fails are.

- The diagnostic accuracy of the test has been established in gold standard studies;
- The test has adequate predictive power in the clinical population in which it will be applied;
- The test can be reliably applied in different settings;
- The consequences of applying the test in the clinical population will be beneficial.


Quite a brief paper that does not give a lot of detail and has limited discussion.


A classic and succinct medical defence of schizophrenia which claims:

- its utility (Kendall and Jablensky, 2003);
- that there are safeguards against misdiagnosis;
- that schizophrenia is not caused by social and psychological events, rather by brain pathology;
- that public stigma is against mental illness, not particular diagnoses and;
- that medical models help reduce individual blame.


This US study addresses an issue raised by anti-labeling people within the psychiatric services and academy. They have argued that stigma is not a problem and does not last. This study sought to evaluate different coping mechanisms which all failed to help. The authors conclude that stigma is a social problem, not and individual one.

Very detailed research report, but particularly interesting for its context of anti-labeling theorists – who would have thought they even existed?


A study testing the relationship between stigma and self esteem which found that the most stigmatised 10% of psychiatric patients were 7-9 times as likely to be in the lowest 10% for self esteem.

Evidence that stigma has detrimental effects on self esteem and the extent to which this occurs.
Longden, E. (2010) Making sense of voices: A personal story of recovery, *Psychosis*, 2(3) 255-259. Eleanor’s story is of being diagnosed while an UG student and how that caused her to adopt all the traits of schizophrenia until she realised that it she was able to choose an alternative way. Quite detailed in how she dealt with the voices.


Moncrieff, J. (2006) Does antipsychotic withdrawal provoke psychosis? Review of the literature on rapid onset psychosis (supersensitivity psychosis) and withdrawal-related relapse. *Acta Psychiatrica Scandinavica*, 114(1) 3-13. Analysis of studies into the effects of withdrawal from antipsychotics medication which suggests that the likelihood of relapse into psychosis is caused by dependency on the medication, inferring the need to only take antipsychotic medication for short periods of time.

**Summary** The pharmaceutical industry has popularised the idea that many problems are caused by imbalances in brain chemicals. This message helps to further the aims of neoliberal economic and social policies by breeding feelings of inadequacy and anxiety. These feelings in turn drive increasing consumption, encourage people to accept more pressured working conditions and inhibit social and political responses.


This is a study of the construction of the idea of antidepressant and the ways in which pharmaceutical companies marketed their products under this label despite the lack of evidence that many of the drugs acted in this way.


Introduction to the drug centred model which Moncrieff puts forward in her book, *The Myth of the Chemical Cure*, as an alternative to the disease centred model that has dominated traditional psychiatry.


Systematic review which concludes that antipsychotic medication may cause some brain changes that have previously been held as evidence of the biological basis of schizophrenia.


Quite interesting introduction as is often the case with psychology papers, then a complex study which tries to ascertain the relative values of different accounts of the psychological processes leading to auditory hallucinations.


Very critical of the development of ‘psychosis risk syndrome’ in DSM-5. Argues that it is unsound to use ideas that give structure to research as diagnostic criteria and that it will result in PRS being treated as an illness in its own right. This in turn will lead to greater use of anti-psychotic medication and may result in people being made psychotic by their treatment.


This paper covers a wide range of ideas in a discursive manner:

1. Can psychosis cause PTSD?
2. Can trauma cause psychosis?
3. Are psychosis and PTSD related types of reactions to trauma?

Useful paper for its review of some very pertinent literature covering a range of ideas about trauma, psychosis and PTSD.


Bit complex, but shows cognitive therapy to be effective and does not appear to make claims that this means relapse is reduced, rather it is about reducing positive symptoms.


Starts by countering psychiatric practice of calling some auditory hallucinations pseudo. This argument has mainly relied on characteristics of voices - external/internal source, with insight or without. This paper makes the case for voice hearing to be considered a dissociative response to trauma.
Provocative and brief paper from Australia discussing several case studies of the link between selling drugs and the construction of diseases.

Study of 82 people in Newtonabbey with diagnosis of schizophrenia. Those with experience of the Troubles had increased levels of depression, anxiety, dissociative experiences and hospital admissions.

Argument that social workers are unique in their ability to challenge institutions through their ‘double identification with both the institution it represents and representing the service users’ relationship to that institution’. This is a common argument in favour of social work, particularly by groups like BASW and the SPN.

An interesting attack on psychotherapy with some of the allegations being important to hear, for example: the use of exposure therapies in which people with OCD are confronted with greater amounts of the thing they fear and; the risk of sexual abuse of patients by therapists.

Paper detailing the increases in use of antipsychotics with children in the US.

This paper is interesting for a couple of reasons. First there is a discussion about the extent to which reported voices are in fact part of the delusions also being experienced by deaf people with psychosis. Second there is a good discussion about the ways in which we impose our understanding as hearing people on deaf people, so we fail to understand the experience because we can only interpret voice hearing in terms of hearing. The paper also draws on Romme and Escher to suggest it is not the hallucinations themselves but the way people experience and cope/not cope that matters.

Pitt, L. (2008), Diagnosis: A label we accept or oppose, Asylum, 15(3) 32-33.
This paper is by two service user researchers. It criticises a bio-medical model of illness and diagnosis and calls for the adoption of a social model of mental distress along the lines of that suggested by Tew.

Detailed and nicely written paper based on experience. Plumb argues against detention and coercive treatment on the basis of her rights to chose. She argues that the so-called new paradigm of proposed legislation in 1999 is actually a strengthening of the old paradigm

Quite an in depth discussion about the origins and changes to the nearest relative and ASW roles.

This is probably one of the most important papers on the relationship between childhood abuse and neglect and psychosis. Essential reading.


This study presents strong evidence that a mental illness model is harmful.


Interesting early paper presenting the results of the survey and interviews with voice hearers following a 1987 TV show. This is the start of the evidence that many people who hear voices do not seek psychiatric help as their voices are not a problem to them. This leads on the Maastricht approach of treating voice hearing and coping as an issue in its own right.


Strong arguments against the proposal of a Psychosis Risk Syndrome including:

   1. If it is to be included it should be a disorder, not a syndrome. Calling it a syndrome allows the process to escape the scrutiny necessary if it were to be called a disorder.

   2. PRS, Brief Psychotic Disorder, Schizophrreniform Disorder and Schizophrenia are 4 diagnostic categories for supposedly one disease process - this is nonsense in terms of medicine

   3. The criteria being too easy to be met.


Some useful data to show that the proportion of detentions that involve people with a diagnosis of schizophrenia is similar in several European countries at around one-third.


An account of the impact of renaming schizophrenia in Japan. One of the interesting things in this paper is reference to the very low number of patients in Japan who are told of their diagnosis prior to the change


A critical paper in terms of outcomes for people with schizophrenia which tries to examine the change over 30 years with many references to a 1979 paper. To some extent it feels speculative rather than evidence based and it maintains the construct of schizophrenia.


Acceptance of criticism of over-medicalization of mental health from the president of the APA. Interesting that the President of the APA needs to ask professionals to rein in the acceptance of gifts in order to help patients to believe they have their best interests in mind.


Study of both US and UK data that reveals a link between multiple traumas and psychosis and that there is a dose response. Paper is speculative regarding how this works and talks of the interconnectedness between trauma, dissociation, hallucinations and delusions.
Evidence of increases in detention, but also of a large increase in appeals and a steady success rate for appellants.

Classic study that helped lead to the dodo bird conjecture that all types of psychotherapies are equally effective.

Stigma, lack of support for families and child-unfriendly hospital contributing to problems faced by children.

Critical discussion of direct payments and some suggestions for ensuring their success in the future and with mental health service users.

Strong arguments that current medical practice is based upon coercion and that this might be a breach of human rights, the right to experience psychosis and the right to be supported in that process. The paper argues that the policy context of mental health services is not compatible to human rights in terms of choice of treatment.

Excellent paper with some very important arguments in favour of ending coercion.

Very useful paper in terms of describing how and why direct payments are used by mental health service users. Usual stuff about limitations due to resources, but doesn't really look at practitioner attitudes, other than to suggest in the conclusion that the principles of choice that lie behind the direct payments system could be compromised.

This is the Australian study that Hammersley refers to as showing no link between CSA and VH, but as it is a prospective study it is only looking at children where the CSA was known and therefore the children had some forms of treatment. However, rates of childhood mental disorder and affective psychosis were higher.

Insight is associated with compliance but also with depressed mood and low self esteem when perceived stigma is high. Study aims to understand this in order to increase compliance. Interesting because the measure of insight includes awareness of need for treatment, and this is then correlated to compliance! Also perceived stigma becomes self stigmatizing!

A review of changes in medicine that has led to what Sullivan describes as ‘the new subjective medicine’. In the introduction it does appear that the significant changes in terms of the value of subjective patient views are in relation to questioning whether preventing death is always desirable.
Two phases in bioethics, first respecting patient decision making autonomy, second patients' capacity to make assessments of health. These question the validity of always preventing death.

Interesting reference point for significant developments in patient involvement within (physical) medicine. What is interesting is that mental health appears to be ignored in this discussion.

In an abbreviated version of his book which was probably the most influential publication of the so-called ‘anti psychiatry’ movement, Szasz makes a clear and succinct argument against the continued use of the concept of mental illness.

Literature review and analysis which highlights perceived conflict between risk and self directed support. Draws heavily on Spandler.

Review of homicides in UK. Reference to the start of the call for enquiries in 1995 and hence the raised awareness of mental health related homicide.

Very useful paper which brings together a lot of ideas about what should be in a social model of mental health.

Important study as it shows good evidence of an interaction between genetic risk and environment in terms of family skills. Outcome could be that families with skills can prevent the development of psychosis or that those without skills are likely to provoke it. Certainly a strong argument against the use of drugs to treat what is clearly environmentally induced if the environment can also be protective.

Argues that the study shows a genetic liability.

Literature review to determine the relationship between genetic and environmental factors. The paper starts with the assumption that the genetic contribution is evident and then tries to assess the environmental influences, concluding that Schiotaxia is a useful concept. This is a predisposition based on neurological changes that develop as a result of genetics and early environmental influences which create the predisposition to develop schizophrenia as a response to later events.

This is an attempt to try and reconcile two opposing sets of evidence, but I wonder if the problem is the inability to give up on the notion of schizophrenia. There is potentially a role for genetic and biological explanations in a non-Kraepelinian understanding of madness. The critiques of Kraepelinian psychiatry is not necessarily anti-genetics.

Brief debate between Turkington and McKenna regarding the merits of using CBT with psychosis.

Makes an argument for replacing schizophrenia with salience syndrome.


Paper questioning the usefulness of schizophrenia as a diagnosis. First issue is that the diagnosis is more associated with the need for care than with any natural phenotype. Second issue is that there is insufficient validity in the way schizophrenia is distinguished from other psychoses. Evidence also suggests that discussing symptoms is more useful to patients than giving them labels via diagnosis. The term schizophrenia implies that it is something that exists and it also leads to stigma. The diagnosis is iatrogenic in that the stigma is very debilitating. Japanese experience of moving from illness to syndrome as part of a stress-related model has proved positive.

Van Os proposes ‘salience syndrome’ as an alternative. ‘Salience is about how internal or external stimuli can become attention-grabbing and how this, if it is not willed, can lead to perplexing experiences that result in a search for an explanation that are subsequently recognised as delusions’ (p. 314). He argues that although there may be other labels which reflect symptoms, they have much greater potential to become stigmatizing. He suggests the obscurity of this term is in its favour.


Quite a heavily quantitative study, but it shows 4.2% of sample as having key symptoms of psychosis, delusions and hallucinations.


An example of how social factors come into play in construction risk and dangerousness.


Good argument for very limited detention powers from someone who says his life was saved by detention. Key aspect for me is his argument against forced medical treatment.


Similar arguments to Moncrieff.


Positive results for psychological interventions with psychosis, particularly with chronic illness.


Reference to 3 MHA case decisions:

1. F v West Bershire HA 1989. Rejection of Ian Brady’s case that he had the right to refuse to eat. S63 of MHA cited ‘The consent of the patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering . . . if the treatment is given by or under the direction of the responsible medical officer (835) too justify his forced feeding.
2. B v West Croydon HA 1995. Court said s. 63 applied not only to treatment for a mental disorder, but also to treatment for the effects of that disorder.
3. R ...v MHRT ... no date: Re. s. 73 and discharge, it is not for the patient to have to prove he is no longer ill, but for the state to show there are grounds for detention when refusing discharge.
Useful paper which proposes that the status of social work client or service user is a source of oppression that is ignored by anti-oppressive social work.

Arguments in favour of service user knowledge.

Editorial defending the inclusion of PRS in DSM-5. Argument essentially based upon the presumption that it exists because clinicians come across a lot a people before they meet criteria for psychosis itself.

This paper introduces the idea of a post-medical era and discusses how lifestyles should be defined for research in this era. This is seen as individual choices, but in a context that may be controlled by other factors, especially social and economic.
It discusses amongst other things, coping, as applied to general health.
Useful to link into discussion about post-psychiatry and in relation to coping as an accepted health strategy that should be considered as legitimate in comparison to the coercion of psychiatry.

Argues that mental health social workers have to balance everything, but concludes by suggesting that control brings care.

Interesting comparison of the different provisions of legislation in various countries.

**Book Reviews**

Richard Bentall concludes this book with an argument to end compulsion in the treatment of psychosis. He convincingly claims that this is not based on a deontological approach as may have been the case for Thomas Szasz in the 1960s, but rather on the growing evidence that neo-Kraepelinian psychiatry has been wrong and that in practice compulsion does not help people with the difficulties they experience with psychosis. Bentall argues that there are at least four reasons why coercion is unhelpful.
First, psychiatry in which the power to treat has been invested, has so far failed to show an adequate understanding of mental illness to be able to justify the treatments they prescribe. Much of this book explores the problems with the so-called evidence upon which psychiatry has depended for the past century. As in his earlier book, *Madness Explained*, Bentall reiterates his arguments concerning the lack of validity for treating psychosis as the result of two illnesses, schizophrenia and bipolar disorder. Instead he proposes that problems such as hallucinations and delusions need to be treated in their own right and he outlines some of the evidence to show why this is so.
Second, the pharmaceutical treatments prescribed for psychosis are not only generally ineffective, they have harmful side effects. Bentall explores the nature of the research that supports the use of antipsychotics and casts doubt on the quality of its findings. While there is some evidence for immediate benefits in their use to
relieve symptoms of psychosis, there is considerable evidence to suggest that their long-term use is both ineffective and harmful. The pharmaceutical industry would appear to be the most significant beneficiary of much psychiatric practice. He contrasts psychiatry and oncology, asking the reader to consider why psychiatrists have persisted in treating people when the medication has failed.

Third, coercion can harm people’s psychological capacity to recover and is therefore intrinsically wrong in relation to mental health. Bentall not only rejects the neo-Kraepelinian illness model of psychosis, he has outlined a number of ways in which the so-called symptoms may arise. He describes the extensive work being done within clinical psychology to understand how life experiences might impact on mental processes. Bentall also presents evidence from within some critical areas of psychiatry such as Mosher’s Soteria project and Romme and Escher’s Maastricht approach to show how psychotherapy can be effective. There is an interesting discussion of the research undertaken into the use of cognitive behavioural therapy and how unlike drug treatments, this is aimed at helping people cope with their delusions or voices rather than ‘cure’. As such they are aimed at helping people develop their own capacity to cope rather than masking the problem.

Fourth, compulsion is unhelpful in establishing a therapeutic relationship that could be helpful in recovery. Much of the research concerning psychotherapy that Bentall reviews points towards the ‘Dodo’ theory, the idea that it does not matter too much which approach to therapy is used, but rather the greatest consistencies are by therapists. One aspect that does appear to be particularly significant is the therapeutic relationship which of course would be difficult to establish with compulsion. Bentall talks of the patient and therapists having a shared enthusiasm for a particular approach and it may be this enthusiasm that is most beneficial. This certainly rings true with the importance placed on relationships within a number of experiential accounts.

While exploring psychiatry and clinical psychology, this book is written for a mixed readership. The early chapters give a very interesting and somewhat harrowing account of the development of both these fields from experimental surgery, insulin coma treatment, ECT to the development of antipsychotics; and of psychoanalysis and clinical psychology. For much of the past hundred years there has been a contest between those who valued the patients’ view and those who have seen people with psychosis as irrational.

... Kraepelin’s methods ... did not require practitioners of psychiatry to get to know their patients very well... instead ... patients were considered as bearers of symptoms rather than as people with histories and stories to tell. (p. 32)

By the end of the book Bentall is able to convincingly conclude that:

Good relationships, it seems, are a universal therapeutic good, and may yet turn out to be the single most important ingredient of effective psychiatric care. Efforts to improve therapeutic relationships are therefore likely to result in substantial benefits for everyone concerned. At the tail-end of the neo-Kraepelinian era, after decades in which clinicians have neglected the personal dimensions of treatment and placed their faith in biomedical remedies for the miseries of life, this idea seems almost revolutionary. (pp. 260-21)

This revolution is not so much anti-psychiatry as anti-bad psychiatry.


This book is about the author’s personal and scholarly journey into the world of the Hearing Voices Network and how it has affected her understanding of mental distress as a professor of psychology in the US. It is also about the ideas themselves, ideas which have come from people with experience of psychosis and which have become a major challenge to traditional medicine and psychology.

The book begins and ends with a description of Agnes Richter’s jacket which is part of the Prinzhorn collection of art by asylum inmates at the University of Heidelberg. Agnes Richter was detained in hospital for nearly 25 years, from 1893 when she was 49 years old until she died in 1918. During that time she took apart and re-made her asylum uniform into a jacket, into which she stitched a massive array of words, not
yet fully deciphered. This iconic artefact provides a reference point from which Gail Hornstein explores the narratives of mental patients, especially in the UK. In particular she explores the way in which those devalued voices have challenged the traditional medical view that they are simply ‘the ramblings of insanity’.

The book focuses on a number of different people, several of whom took part in the British Library’s Mental Health Testimony Project. These video recordings were of particular interest and value to Hornstein who has spent much of her career studying the writing of mental health patients. Indeed she has compiled a very useful *Bibliography of First-Person Narratives of Madness in English* which can be downloaded from her website – [www.gailhornstein.com](http://www.gailhornstein.com). Throughout the 26 chapters of the book the author focuses on particular aspects of her studies over the last decade. There are chapters about specific people who she has met or viewed at the library, there are chapters describing particular events she attended and there are others through which she shares her thoughts and reflections. What links all these is the paradigm shift that is taking place within mental health through people challenging the established medical knowledge about psychosis.

Many of the people Hornstein meets are concerned with countering the stigma and discrimination they experience due to their diagnoses and other people’s perceptions of them, but beyond this what those connected to the Hearing Voices Network have also been doing is to challenge their doctors’ knowledge about them and their so-called illnesses. The HVN started as a result of the work of Marius Romme and Sandra Escher in Maastricht. In the mid 1980s Romme, a psychiatrist was asked by one of his patients to work with her in a way that respected her own understanding of her voices. Rather than treating them as auditory hallucinations that needed to be suppressed, she wanted to be able to discuss the voices with him. The changes that have evolved from that time have challenged the medical orthodoxy in relation to psychoses to such an extent that while the American Psychiatric Association and the World Health Organization persist in re-writing their Kraepelinian manuals (DSM and ICD) they are increasingly discredited, although not yet disempowered.

Hornstein’s outsider perspective of the HVN and of the mental health service users’ movement in the UK is particularly interesting. As an American psychologist, she is surprised by the extent to which the HVN has been supported by the NHS to bring this different explanation for voices to the attention of professionals and service users. At the outset of her journey Hornstein is not aware of similar groups in the US, but with her awareness heightened she soon finds a group called the *Freedom Center*, which works in much the same way as the HVN groups in the UK. These groups do not try to interpret what people say in order to diagnose or assess, rather they provide a space where people will listen and engage with each other helpfully.

This is an academically interesting book to read for anyone studying mental health, but as well as that it is an enjoyable and well written story about discovery and learning. Hornstein’s own enthusiasm and feelings often come through, like when she describes how she managed to uncover the true identity of John Custance, author of *Wisdom, Madness and Folly: The Philosophy of a Lunatic*, and how she went on to meet with his son and discover what it had been like to live with him. She discusses her fears when delayed on a train because someone had been killed on the track. She expresses her wonderment when finally left alone with Agnes’s jacket in a sanitised cellar in Heidelberg. For many reasons I have enjoyed reading this book and I would like to commend it to others.


Joanna Moncrieff makes a radical suggestion in this book; that doctors should prescribe psychiatric drugs on the basis of the effects that they will have, rather than on their supposed curative properties. Drugs have all kinds of effects and when they are being used to treat diseases – any unwanted outcomes are considered side effects which are part of the risks that are taken for the supposed beneficial effects. However, given the lack of evidence for the purported treatment of specific diseases, the prescription of drugs in accordance with this ‘disease-centred’ model comes in for considerable, critical scrutiny and Moncrieff proposes an alternative ‘drug-centred’ model. This approach does not consider the drugs to be correcting an abnormal brain state as insulin might correct for diabetes, rather that they create an abnormal brain state which may
be desirable in certain circumstances. This idea goes against the conventional wisdom of psychiatric prescribing since the 1950s and challenges the presumption of psychiatrists that mental distress results from brain diseases.

The use of psychiatric drugs to treat supposed diseases such as schizophrenia and bi-polar disorder was preceded by other physical treatments, notably insulin coma therapy and electroconvulsive therapy. In the 1930s it became commonplace in Germany, Britain and the US to treat people diagnosed with schizophrenia by injecting them with insulin to force them into a coma for about two hours. It was believed that this process was disease specific and by the late 1930s Moncrieff says that research papers reported success rates of between 70% and 90%. Also at that time psychiatrists were inducing convulsions in people diagnosed with schizophrenia on the basis that the disease was antagonistic to epilepsy. Drugs were replaced with electricity and this treatment continues today, thought for people with depression rather than schizophrenia. The disease specificity of the treatment is still claimed – it’s just that the ‘disease’ has changed!

The use of neuroleptics which were developed in the early 1950s soon became a continuation of this approach to mental distress; treating that distress as the result of a disease which creates an abnormal brain state. Prior to this, drugs were generally not considered disease specific, but their belief in the specificity of these other physical treatments led psychiatrists to change their view of medication. So the drugs that had started out as neuroleptics had become antipsychotics by the mid 1960s and their undesirable effects were rediscovered as side-effects. A medical reality was constructed in which patients had diseases caused by an abnormal brain state. In another reality, people were and still are being given drugs which create an abnormal state. They are chosen to receive these treatments because they are experiencing emotional and mental distress which may cause upset to others and because it suits the ambitions of psychiatry to be closely aligned to medicine.

Moncrieff reviews the evidence for the effectiveness of these medicines and finds it lacking. Indeed there is evidence that suggests people will make a better recovery if they are not treated with neuroleptics. Second generation neuroleptics are purported by the pharmaceutical companies to have lesser side-effects and to be more effective, but independent studies have failed to find any evidence to support this view. Similarly, the claims made for early intervention with drugs are unfounded and as Moncrieff points out there is considerable cause for concern in the current trend to lowering the age of onset of treatment.

Moncrieff describes the actions of neuroleptics from a drug-centred perspective and argues that when these are understood in terms of their impact on the body and brain rather than in terms of treating a disease, ...

... it is easy to understand how they can produce an apparent improvement in people with psychosis who are preoccupied with their own internal world. The general reduction in mental activity and accompanying psychic indifference are likely to dull the import of delusional thoughts and hallucinatory experiences. Patients confirm this view. Those who find neuroleptic drugs helpful do not regard them as removing their abnormal experiences or ‘symptoms’, but suggest that the drugs help them to disengage from their symptoms and become less troubled by them. (103)

The damage these drugs do though is immense and includes ‘brain atrophy, neurological impairment, cardiac toxicity and metabolic disorders’. Moncrieff sets out the evidence for mental health professionals to ask serious questions about whether these are worth the minimal benefits that might be gained from the use of neuroleptics.

In the second half of the book Moncrieff goes on to similarly examine the role and use of anti-depressants which had a similar history of changing from being described in terms of their effects to a supposed disease specificity.

Moncrieff argues that a drug-centred psychiatry would be more democratic in that doctor and patient would need to discuss the relative merits of different effects that might be gained from taking drugs, including whether they might lead to increased tolerance. Treatments would be decided from such discussions and especially from patients’ experiences of taking the medications. Research agendas would need to change to
support the knowledge required for this different practice and society would need to reconsider the way in which political and behavioural problems have been medicalized, affording psychiatry the power to treat without consent and to detain people in order to do this – Moncrieff argues that a drug-centred psychiatry would be more akin to the relationship between a patron and the apothecary.

This book challenges the medicalisation of psychiatry. Moncrieff likens the disease-centred model to ‘an ideology’ and ‘a system of false knowledge’ that psychiatrists are taught to believe.


[I wrote this review some time ago but have included it as I think this is an excellent book]

This is an account of a study in Kitchener-Waterloo, Canada, which aimed to examine whether and to what extent a paradigm change had taken place in community mental health. The authors were concerned with a shift from a traditional to an empowerment-community integration paradigm.

The book begins by setting the context to the study, including a very clear and informative chapter on what exactly the authors understand to be involved in these two paradigms. The traditional, which may include medical-institutional and community treatment-rehabilitation approaches, is very much what we might expect within an individual model of disability: people are treated as patients or clients rather than citizens; the professionals remain in control; stigma, while recognized, is explained by individual deficits; and services are segregated. On the other hand, the new paradigm places an emphasis on: consumer/survivor participation and empowerment; integration and support; and social justice. There is a strong sense of people being ‘cared about’ rather than ‘cared for’ and this is shown in their adoption of a feminist concept of power,

... that is no longer based on individualism and ‘power over,’ but instead emphasizes ‘power with’. (p. 22)

There is also a very constructive approach to community integration that recognises this as more than the imposition of civil rights, but as one that needs to involve others in these communities. Psychoanalytic analyses of community care have shown that individualist approaches in the arena of mental health can have negative consequences, and in setting out their key concepts of this new paradigm the authors appear to be aware of this potential. Whilst they warn that some consumer/survivor led initiatives may be replicating the traditional paradigm, their theoretical analysis of the empowerment-community integration paradigm is one that does not deny or discard biological aspects of mental illness,

... but seeks to place such issues in a broader ecological context of power, community and social justice (p. 36).

Methodologically the authors have sought to study the issues from within a social constructivist paradigm using a participatory action research approach and qualitative methods. This is explained quite clearly and thoroughly with much of their emphasis being on the means by which consumers/survivors have been involved within the direction and the action of the study. The authors were able to effectively use their position within the academic and welfare establishment to attract large sums of money to Kitchener-Waterloo and then to ensure that those directly affected by the topic of their study were given a great deal of control over how it was used. While purists might argue that the consumers/survivors should have had more control, the aim in this study and in the approach of the authors is much more one of an alliance from which neither they nor the consumers/survivors are excluded.

The context of the changes is very familiar with a growing move towards families in particular recognising the need for additional support over a period of time that people were being discharged from hospitals to a supposed community care system tat actually meant little or no support. The changes were taking place in the last quarter of the 20th century and involved the development of self-help groups which then became politicised. The changes in Ontario in the late 1980s and early 1990s are considered to be unique in North America. State policy was concerned with encouraging and funding the development of community resources that were supportive of empowerment and integration. However, by the mid 1990s the election of
a conservative government in Canada had brought about a change in emphasis - their concern was with risk and this promoted a more professionalised 'assertive-outreach' approach which delivered control rather than support for integration.

The book examines the effect of these various changes on three local organisations and on individuals using their services. The conclusions are in line with the promotion of the new empowerment-community integration paradigm. I think that what I have found most useful in reading this has been the detail of ideas of how this can be achieved. This is not a book that simply presents grand ideas and then leaves it to others to work out what that might mean in practice, it is a practical book. I also found it very useful as a guide to some positive North American literature on such things as recovery models of mental health. I would certainly recommend this to anyone involved in teaching or practice in this area - it is a book that I shall be re-reading and using for some time.


This book tells four stories about the ways in which the US psychiatric and pharmaceutical industries are working to export western understanding of mental 'illness' to the rest of the world. In relating these tales from Hong Kong, Sri Lanka, Zanzibar and Japan, Ethan Watters conveys the arrogant certainty of western psychiatry that distress can be reduced to genetic susceptibility and neurological, chemical imbalances for which they can offer highly profitable, drug solutions. At a time that the American Psychiatric Association is engaged in writing the DSM5, the latest version of its Diagnostic and Statistical Manual of Mental Disorders, this book reminds us of the strong and often corrupt links between the creators of these so-called disorders and the pharmaceutical industry.

The rise of anorexia in Hong Kong in the late 1990s demonstrates the extent to which the DSM is itself instrumental in creating the symptoms that define the condition. When western concepts of eating disorders as diseases with specific symptoms were rapidly publicised in 1994, the numbers of people with eating problems in Hong Kong not only increased, but they began to present with the DSM defined symptoms of fat phobia and distorted body image. Watters recounts the experience of one Hong Kong psychiatrist, Sing Lee, who had been trying to understand why women with eating disorders in Hong Kong did not follow the typical pattern of symptoms as had been laid down in the DSM. His work suggests that while the outcome of the distress – starvation – may be common across cultures, the distress itself is likely to show cultural heterogeneity. Lee explains the change as a result of professional and lay discourse influencing how people express their anxiety and unhappiness. The change in Hong Kong became unstoppable.

At the end of 2004 when the tsunami hit Sri Lanka, one immediate reaction of the US was to send in trauma experts to treat and educate the local population of the dangers of PTSD (Post Traumatic Stress Disorder). In refugee camps throughout the island, groups of trauma counsellors and researchers vied with each other to try their competing methods on the displaced population. In this story Watters follows the efforts of several people who were wary about the imposition of an idea that seemed alien to the way trauma had been understood and dealt with in Sri Lanka until that time. Watters describes how in the Buddhist influenced culture of Sri Lanka, the communal use of euphemistic speech was important to the process of recovery and existence. People found ways of talking about their experience indirectly so as not to upset their fragile selves and most of all to avoid developing ‘a terrified heart’. The US PTSD counsellors behaved differently. They valued open expression of what had been experienced and as such were working in direct conflict with the existing communities.

But it is not just in other cultures that the DSM notion of PTSD has proved negative. This disorder started life as a way of trying to recognise the specific experience of being a US soldier in Vietnam. To gain medical recognition however, it had to become culturally less specific and soon came to be applied to the consequences of almost any type of traumatic event. However, throughout the 1990s researchers found that PTSD counselling itself was responsible for people developing the very symptoms it was aimed at preventing. As with anorexia in Hong Kong, the DSM was creating mental distress.
In Japan, the marketing of depression in 2001 was a much more deliberate and deceitful act. Watters follows the story of how a UK/US company, GlaxoSmithKline, went about persuading the Japanese public that they were suffering from depression which was caused by an imbalance of serotonin in the brain, which they could treat with Paxil. By the end of 2002 GlaxoSmithKline’s sales of this drug had reached $100m in Japan and by 2008 this had risen to $1bn. Prior to this, most US drug companies had accepted that Japan was not a good market for these types of drugs as the Japanese did not generally recognise depression as an illness. Watters reports that in Japan, people had tended to value the emotional and spiritual gains that could come from some suffering and that the idea of taking drugs that would stimulate them was culturally alien to many people.

GlaxoSmithKline are now embroiled in various legal battles in the US over the side effects of Praxil. The story of schizophrenia in Zanzibar is of a different tempo, still concerned with contrasting the differences between beliefs about illness in that country with those from the west, but not directly concerned with a particular historical event. This story highlights the humanity and inclusion of one family, who while accepting some aspects of western medicine, nevertheless retain a different understanding of psychosis to that written in the DSM

Crazy Like Us is written by a journalist, which I think has made it interesting, informative and relaxing to read, but by academic standards lacking in proper referencing to the bibliography. However, that may limit the extent to which this can be used as a source for future writing, but it does not diminish it as a very good read.

This book is an impressive piece of investigatory journalism into the iatrogenic effects of the pharmacological era of psychiatry. Robert Whitaker describes the growth of psychiatric morbidity in the US as of epidemic proportions. In 2007 the numbers of people receiving disability benefits in the US due to mental illness was almost 4 million, about 1 in every 76 of the population. This was more than double the rate in 1987 and six time the rate in the mid 1950s. Furthermore, the numbers of children considered disabled by virtue on mental illness rose thirty-five fold between 1987 and 2007 to more than half a million. As a proportion of all disabled children, those with mental illnesses rose from about 1 in 20 to more than half. In this book Whitaker sets out to answer a question, ‘Could our drug-based paradigm of care, in some unforeseen way, be fueling this modern-day plague?’ Unlike some of the academics who have also written about the ill-effects of psychotropic medications, Whitaker does not hold back in attributing fault to the psychiatric profession and drug companies for their actions.

The book takes the reader through a history of the development of the brain disease paradigm which supports the use of medication for mental distress. Whitaker looks at the incidence of and expected outcomes for people of schizophrenia, bi-polar disorder and depression prior to the psychopharmacological era and compares this with the situation today. This is a story of decreasing recovery, increasing severity and of relatively rare conditions becoming relatively common in the USA. He doesn’t explore whether the patterns are repeated to the same extent in other countries other than to quote the WHO findings that recovery is better in developing countries where people are less likely to be treated with drugs.

There are two major strands in Whitaker’s analysis of the recent history of psychiatry in the US. First the search for magic bullets in medicine influenced the way that pharmaceutical companies sold their drugs. Drugs that started out as neuroleptics became anti-psychotics because they initially appeared to have a positive impact on people with psychosis. As the drugs were found to have particular effects on the chemistry of the brain, the idea that they were correcting some kind of imbalance began to take hold. Initially the market for these drugs was relatively small, but when the anti-psychiatry movement began to challenge the credibility and validity of psychiatry, the idea of a brain disease became its saviour. In this second strand psychiatry reinvents itself as a biological science rather than as a psychotherapeutic one. Freud is out and theories of chemical imbalances and abnormal brains are in. Environment is replaced by heredity.
Although the research funded by the pharmaceutical industry showed that people who are prescribed medication have worse longer-term outcomes than those who do not, that the drugs cause a supersensitivity syndrome in which the brain is altered by the drugs making people more ill than they might have been, that withdrawal from drugs is likely to increase the incidence and severity of psychosis; the story told to the American public was that these drugs were the magic bullets that could correct levels of chemicals like dopamine or serotonin and cure people of their madness. The detail of the deceit that Whitaker discusses is shocking, but it is his exposure of the way psychiatrists and drug companies have extended their disease creation to children that is truly breathtaking.

When Kraepelin first identified a condition of manic depression, there were only a small number of people presenting in this way and they were likely to recover with a year or two. Indeed, he constructed this idea of an illness in contrast to dementia praecox (schizophrenia) which he saw as having poor long term outcomes. This was also a condition that never occurred in children; now in the US children as young as 2 years have been diagnosed with bi-polar disorder and are being prescribed neuroleptics which will inevitably lead to severe brain damage. Bi-polar disorder is the latest in a series of epidemics to have been diagnosed in American children; it follows on from depression and ADHD. As many as 1 in 15 children in the US now enter adulthood with a diagnosis of a severe mental illness. Children who may have started with some simple behaviour problems at school will find themselves on a path that leads not only to a life of iatrogenic disablement, but one that is about 25 years shorter than it might have been if they had not been medicated.

The US Teenscreen programme which is funded by the drug companies aims to simplify the process of diagnosis. A short and standardised set of questions is being used to identify so-called mentally ill children at school and their parents are then told that they would be bad parents not to adhere to medication regimes. Programmes such as this are being supported by the American Psychiatric Association which is also proposing the creation of a new Psychosis Risk Syndrome in the revised DSM. This will help them to identify children at an even earlier age and to prescribe medications with the intention of preventing illness, whereas in reality it will cause illness.

Whitaker does conclude his book with some positive ideas about how to tackle the problems created by a drug-based psychiatry. He points to the Finnish needs-adapted approach as an example of the higher recovery rates that can be achieved with psychological interventions; this has been well documented in European psychiatric literature.

However, he reserves his greatest praise for the work of Jim Gottstein in Alaska, a lawyer who has successfully challenged the right of the state to forcibly medicate people with psychiatric drugs because of the harm they can cause. Gottstein’s work is impressive, see for example Alaska Law Review 25(1) 51-106. His approach is similar to other campaigns which have followed the signing of the UN’s Convention on the Rights of Disabled People a few years ago. While the Convention stated that people should never be detained on the grounds of having a disability, including mental illness, the UN’s special rapporteur on ‘torture and other cruel, inhuman or degrading treatment or punishment’ also questioned the use of neuroleptics without consent, suggesting that this should be considered illegal along with other forms of torture. Robert Whitaker’s book provides access to the evidence to those pursuing such approaches.