Clinical Psychology Forum

Clinical Psychology Forum is circulated monthly to all members of the Division. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

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Editorial

Ethics Column Compendium

Clinical Psychology Forum

THE ETHICS COLUMN in the Clinical Psychology Forum began in 2009 as a way of linking the work of the British Psychological Society’s Ethics Committee to the wider membership of the Division. The initial articles included some account of the work of the Ethics Committee and also the work of the Board of Ethics of the European Federation of Psychology Associations on which the Society is represented. Since then the approach has become less to do with reporting on the work of the Ethics Committee than on providing a space for an ethical viewpoint to be presented and it is these articles that are included in this compendium. The authors are mainly those who are or have been the Divisional representatives on the EC (David Pilgrim, Steven Coles and Tony Wainwright) with invited contributions from others. We are keen to include a wide range of voices in this column so if reading this compendium inspires you to consider contributing, please get in touch.

The articles we have selected cover five themes: regulation; our relationship with diagnosis and psychiatric treatment; exploration of ethical standards; ethics in contemporary clinical practice; and finally, ethics from a more broadly community psychology perspective.


Tony Wainwright & Steven Coles
In Human Science we find a range of theorists disagreeing about what exists, what is legitimate knowledge and how we should investigate experience and behaviour (Foucault, 1973). However, one reasonable point of consensus from theorists as diverse as Marx, Skinner, Sartre and Bourdieu is that human action is enabled and constrained by contingent contexts. Taking this consensus as an underlying rationale, in this article I will explore some points about therapist sexual abuse and the ways in which context, not just moral exhortation, is important for risk management.

Therapist sexual abuse (TSA) is now recognised as one source of iatrogenic injury to patients and is the commonest reason for litigation about the malpractice of psychological therapists. It is generally agreed that ‘dual relationships’ undermine therapeutic goals, and create conflicts of interest. Investigations of the malpractice may lead to additional human rights violations, when and if patient information emerges and is then placed in the public domain, such as the mass media (Gabhard, 1989).

The response of professional bodies to ‘boundary violations’, including TSA, has been to adopt a Kantian approach, which codifies and makes explicit rules to be followed that respect his categorical moral imperative. The latter alludes to the absolute principle that human beings should be treated as an end in themselves not as a means to end. By contrast, in the case of TSA, the therapist uses his or her patient for their own needs for erotic intimacy and this displaces the needs of the patient (for psychological improvement). The Kantian codification can be found in the British Psychological Society’s ethical guidance. Here are sections 4.2 and 4.3 from the Society’s current Code of Ethics and Conduct:

4.2 Standard of avoiding exploitation and conflicts of interest

Psychologists should:

(i) Remain aware of the problems that may result from dual or multiple relationships, for example, supervising trainees to whom they are married, teaching students with whom they already have a familial relationship, or providing psychological therapy to a friend.

(ii) Avoid forming relationships that may impair professional objectivity or otherwise lead to exploitation of or conflicts of interest with a client.

(iii) Clarify for clients and other relevant parties the professional roles currently assumed and conflicts of interest that might potentially arise.

(iv) Refrain from abusing professional relationships in order to advance their sexual, personal, financial, or other interests.

(v) Recognise that conflicts of interests and inequity of power may still reside after professional relationships are formally terminated, such that professional responsibilities may still apply.

4.3 Standard of Maintaining Personal Boundaries

Psychologists should:
(i) Refrain from engaging in any form of sexual or romantic relationship with persons to whom they are providing professional services, or to whom they owe a continuing duty of care, or with whom they have a relationship of trust. This might include a former patient, a student or trainee, or a junior staff member.

These Kantian strictures are fine as far as they go but they limit our focus for the topic of TSA to describing what is right and wrong. If we are to explore how TSA (and other ‘boundary violations’) emerge then we need more to go on. One starting point is to elaborate the Kantian view with one from Hume, which focused more on the sentiments linked to ethical and unethical action in contingent settings. These sentiments are hinted at in the above definitions, which include notions such as ‘duty of care’. Care is a sentiment and emotionalised human process, not an objective fact. Care reflects a concern for the needs of others (i.e. it is an inner impulse and experience, not merely a ‘skill set’ emerging from a completed professional training). That impulse then impels virtuous action, independent of our level of training.

Indeed it is quite possible for us to be highly trained and yet still act in a manifestly uncaring way. This is why ‘credentials’ can be a rhetorical diversion in debates about good and bad care. Their relevance though is that those of us who are well trained are more culpaible, when and if we act in a maleficient manner. Given this point, professional groups have been rightly criticised for their tolerance of malpractice when tending to suspend and rehabilitate transgressors, rather than permanently debarring them from practice (Pilgrim and Guinan, 1998).

A contingent and sensed obligation to help others probably flows from a mixture of guilt, pity, the therapist’s own personal vulnerability or injury and a sentiment of quasi-parental love (Rippere and Williams, 1985). These feelings then alloy in various ways from practitioner to practitioner, to become positive compassionate caring. However, other feelings can operate in care work, including, sexual desire, hatred or the enjoyment of power over weakness, which might undermine a compassionate sense of duty to others (Winnicott, 1994). When this happens then we encounter malign sentiments, which displace ‘moderated love’. The latter term is used by Gillon (1997) and is adopted from the Scottish theologian Alastair Campbell, to describe how a benign, non-erotic, orientation between carers and those cared for, should be the moral imperative in any setting.

Apart from the malign sentiments undermining a ‘duty of care’, the Society’s code of ethics also notes the matter of the ‘inequity of power’. Indeed sexual exploitation invariably includes the enjoyment of power over the weak by the strong (the ‘sexy’ erotic dimension may divert our attention from this fundamental point). This is why any person who attempts to rationalise TSA, as a simple matter of sexual intimacy between consenting adults, is missing the point. Turning to Hume again, we would do well to ask ourselves why any of us have a sentiment of desire to earn a living from developing highly personal relationships with unhappy or dysfunctional people. Inherently the latter have less power than we do because of the asymmetry of the therapeutic relationship.

That focus on the exploitation of power comes through from reviews of the literature on TSA and reminds us of the fine psychological line between immorality and illegality. In some States in the US, TSA is a crime and in the UK the Sexual Offences Act of 2003 can be invoked by the police to prosecute mental health workers in this regard. Halter et al. (2007) simply frame TSA as a crime, when they point out that: ‘The use of sanitised terminology, such as “boundary violation” should not ‘obscure the fact [sic] that some of these encounters have more in common with other [sic] sexual offences than with ordinary clinical practice…’ Given the uneven manner in which TSA has been criminalised internationally, their presumption could be challenged, but the point is also well taken from them and should be reflected upon by all clinicians and trainers.
Kant and Hume between them set the broad parameters of the ethical discourse about TSA. This is all fine and deserving of our continuous critical reflection about practical probity, our motives and those of our colleagues. However, it leaves us still with an emphasis on moral exhortation for individuals, which is a necessary but not sufficient process to minimise iatrogenic risk to patients. Indeed I would argue that by limiting our consideration of TSA to personal education about ethical strictures (in basic training and CPD) and the supervision of individual practice, we risk missing the point about the importance of context.

This is not to argue that education and supervision are unimportant, but it is to argue that they might provide us with an illusion of safety about good professional practice if they are the only strategies deployed. As for investigation of malpractice, this is always after the dreadful has happened and the risk management recommendations that may appear are about closing the stable door after the horse has bolted. These episodically publicised accounts of patient exploitation give us the wisdom of hindsight case by case, but they do not necessarily engender needed systemic changes in service policy.

What then could we do about the context of our work to alter the above limited focus? Some of these are very obvious but they will hit some barriers about therapeutic traditions. First, we could problematise individual therapy. Individual case work creates the basic condition of one-to-one intimacy required for TSA to emerge and for ‘moderated love’ to be displaced by malign sentiments. Group and family therapy offer a less risky scenario.

Second, we could abandon our acculturated assumptions about seniority. Experienced therapists are not necessarily more ethical in their practice than neophytes. Indeed, a depressingly common scenario is for an older male practitioner to inveigle a younger female patient into an erotic encounter. Older therapists tend to be less scrutinised in their practice than younger ones, which creates a context of complicity with the risk of TSA in a care setting.

Third, we could grasp the nettle about sexual orientation. Our concern to avoid discussion of the latter (on equality grounds) is all very well for professionals but it puts patients at unnecessary risk. If the sexual orientation of all therapists became part of a deliberate policy of patient protection then it would allow us to develop policies of low risk case allocation. Basically, the latter would involve therapists working with a client group who they have no a priori sexual interest: a male heterosexual therapist should not see a female heterosexual patient, etc, etc.

Unless we develop a more considered policy of risk minimisation about TSA, which takes these contextual points into consideration, horses will continue to bolt and stable doors will continue to be closed. Moral exhortation and education are important but they are not enough. Our current reliance on them is a weak response to a recurring problem. If this claim is in doubt then look at the failure rate of the status quo. Although nearly three-quarters of general psychiatric staff admit to being sexually attracted to patients at times, only 0.9 per cent report acting upon that attraction (Gartrell et al., 1988). This rate of actual involvement increases though for those offering psychological therapies, where we find reported rates of actual sexual intimacy to average at around 8 per cent for male therapists and 2 per cent for female therapists, with a range of 1–12 per cent across anonymous self-report studies (Pope, 1993).

Abusive therapists typically know about ethical guidance. They are often highly educated and ‘credentialised’. Ipso facto appealing to their duty of care has not worked. Anticipatory guilt and fear of discovery did not prevent them from their actions. Many of them have had more than one relationship with patients and when discovered they generally rationalise their conduct to render it innocent or anomalous. If they voluntarily resign from professional registers then they do so to avoid shame not to admit their guilt. These people are beyond the reach of moral exhortation: it is too late. We would be better then putting new effort into the suggestions made above about improving the context of risk rather than rehabilitating these risk takers.

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The case of therapist sexual abuse

References


Regulation of ethical conduct

Misconduct and the British Psychological Society: A personal opinion piece

Issue 241, January 2013

David Pilgrim

At one time, pre-Health and Care Professions Council (HCPC) days, the British Psychological Society (BPS) investigated complaints and dispensed justice. The efficiency of the investigation, and satisfaction with the proportionality of any disciplinary action, were at times open to question and debated by members. Despite this imperfect system, a sort of collective wisdom was developing about the nature of complaints and how to deal with them. For example, mischievous complaints could be understood in context by panel members, who could relate to the complexity of clinical and service settings and scenarios. This wisdom has not seemingly transferred, with ease, to the HCPC. But that is a topic for another article. Here my concern is to alert readers to a simple fact: once regulatory powers were devolved to the HCPC, the Society dismantled its investigatory and disciplinary mechanisms.

The latter now leaves the Society in a state of acute organisational risk, because it relies on third-party authorities to resolve problems of misconduct, linked to members who are an employee (say of a university or the NHS) or on a practitioner register (say of the HCPC or UKCP). This wing-and-a-prayer strategy presumably will only work for so long; hence a colleague’s concern that a scandal is in the pipeline somewhere. Of course, it is an option for the Society to look to an NHS Trust or a university to investigate and discipline employees, who might be accused by a client or colleague of having acted in some way unethically.

But there are two problems with this reliance on others. First, supposing that within the Society’s Code of Ethics and Conduct a rule has been transgressed and requires understanding, within specific expectations of good psychological practice: will an employer be judging the conduct under scrutiny by these particular criteria or by different or even unrelated ones? Second, what if the employee simply resigns before their conduct is investigated? In this situation, an unethical practitioner might have moved on without justice for a past complainant and with no feedback loop and corrective action for prospective complainants.

Moreover (and this might be the biggest risk at present) supposing that a Society member who is accused of acting unethically by a member of the public or a fellow professional is both self-employed and is not a member of a register such as the UKCP or the HCPC. Not only do these organisations only have jurisdiction over those actually on their register, the narrow legal ownership of the title ‘psychology practitioner’ (for now by the HCPC) means that other titles can be employed. For example, a Society member could call themselves a ‘life coach’ or ‘analytical psychotherapist’ or ‘psychological counsellor’. And when they do, and they use
their membership of the Society as part of their advertised legitimacy, under current legal and professional arrangements they are not inherently doing anything wrong. But when and if they are accused of doing something wrong in their practice, by clients paying for their services, or say a colleague from clinical supervision, where is the redress – what then? This scenario of ‘independent practice’ is increasingly common for clinical psychologists, with the marketisation of the NHS.

So maybe we should be panicking, or at least doing something to ward off the need to panic. Not only is the Society in an acute state of organisational risk about this matter, a number of others might arise. For example, we are now in a no-man’s land about the role the Society is adopting about the HCPC and the common expectation that the Society is there, in part at least, to support its members. For now, not only is it not investigating complaints it is also not giving support and advice to members unhappy about the way that they are being treated at times by other organisations. This then begs a question about the point of being a member of the Society. Is it now just a scholarly organisation, if it neither regulates practice nor provides a supportive function for applied psychologists? To my knowledge, that new status has not been declared, but it would be understandable if its members viewed it in that way. (My reading of the current functioning of the Society is that this formulation is accurate but I am happy for anyone to argue that I have got it wrong.) And what extends the identity crisis for the Society is the provision of guidance but with no agreed available sanctions and mechanisms of investigation and discipline to back it up or enforce its expectations. For example, the 2009 version of the Code of Ethics and Conduct is there for us all, but is it just an advisory document? What if a member chooses to ignore the advice; what would be the consequences in an organisation with no mechanism for investigation or discipline?

With these questions hovering, there are two scenarios that could ward off the (eventual and probable) scandal in the pipeline. The first is that some subsystem of the Society now re-owns the old investigatory and disciplinary functions and roles it developed, with its particular stock of knowledge, from the pre-HCPC days. The second is that the Divisions could have that safety net role, about dealing with complaints of misconduct, devolved to them. This second scenario might make more sense in developing particular forms of wisdom about particular forms of practice. Remember that as the largest applied group, clinical psychologists are the most at-risk group at present, but members in other Divisions are also at risk, as well as all of our prospective complainants. As for members on academic contracts it is not clear what would happen if a student or colleagues made an accusation of unethical practice to the Society. Surely it is not good enough to rely solely upon the complaints, grievance and disciplinary processes of a third-party organisation?

The third scenario is that people might wonder what the point is of being a member of the Society and simply vote with their feet, if something is not done urgently about the organisational risk I note above. They might spend their membership money instead on private insurance to protect their practice, having lost confidence in their professional organisation, which offers neither professional support nor an ethical framework with teeth. Thus, a secondary organisational risk of not dealing with the problem I highlight here is that the Society is in danger of losing new lifelong members. If this is being read by a newly qualified clinical psychologist entering the newly marketised world of increasingly independent practice, maybe you could write in and say what you think. Views for all others are of course also gratefully received.

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Regulation of ethical conduct

Publication ethics and fraud in psychological and other research

Issue 243, March 2013

Tony Wainwright

With the contemporary emphasis on evidence-based practice, the research on publication bias and fraud in psychology is worth a look, both because it provides a caveat to over enthusiastic acceptance of everything in the literature, but also because it’s a serious field in its own right. Its importance comes both from the theoretical issues it raises about the status of psychological research, but also what it reveals about how people can be affected by the biases we teach and learn about on our psychology courses and how they can be used to root out fraud. One of the most striking cases for me has been that of Marc Hauser, who published a very enjoyable book on Moral Psychology, which lays out some of the ethical ambiguities in this area (Reich, 2012), but recently had to resign from his chair at Harvard for research misconduct.

Many years ago, Tom Trauer and I published a short article in Forum on clinical psychologists’ attitude to research (Trauer & Wainwright, 1986). Essentially, what we found was that, while it was regarded as status enhancing, it was also likely to be hard work and had high risks for various reasons. The other old area of work it reminded me of was Phil Ley’s classics on professional non-compliance (Ley, 1981) where he did some simple experiments demonstrating that we are all guilty of breaking rules some of the time.

In the light of the publication of the report on Mid Staffs Hospital (Francis, 2013) it is worth quoting him briefly here:

Although it is now well established that patients frequently do not comply with advice from health care professionals…, the question of whether or not these health professionals themselves comply with advice about patient care has yet to be generally accepted as a problem. Indeed, when a hospital scandal breaks, surprise and indignation are usually expressed at the extent to which the health care professionals involved in that situation have disregarded or broken rules. The implied assumption is clearly that rule breaking is a rare event. However, it might not be as rare as is commonly supposed, as will be seen from this brief survey.

To kick off this discussion I would suggest you have a look at a website that is devoted to publication ethics (Committee on Publication Ethics – www.publicationethics.org). This was established in 1997 by a small group of medical journal editors, and now has over 7000 members. It ‘provides advice to authors and publishers on all aspects of publication ethics and in particular how to handle cases of research and publication misconduct’.

The initial impetus to set up the group came from a newly appointed journal editor who encountered four cases of research misconduct and wondered how widespread the problem was. The fact that it has continued and grown is an unfortunate testament to the problem not being simple and not going away.
On their website they have a number of useful guidelines, including advice on retracting articles, ethical editing for new editors, research integrity, and so on. Related to this they also have a number of flowcharts for ethically problematic situations – for example, if you suspect fabricated data in a published paper. These are very simple common sense procedures, but are really useful if you find yourself in one of these situations.

What prompted me to write the column on this area this month was the publication of a special section in the journal *Perspectives on Psychological Science on Replicability in Psychological Sciences* and another on research practices (Pashler & Wagenmakers, 2012; Spellman, 2012). These sections are open access and contain a combined total of 23 papers. They are all available from http://pps.sagepub.com/content/current.

Taking the replicability issue first, there has been some pretty heated exchanges in the literature notably because of – as I understand it – one author in particular, Gregory Francis, professor of psychological science at Purdue University (G. Francis, 2012). He has published a number of papers where he looks at a particular study and estimates the likelihood of publication bias from how good the results are. If they are ‘too good’, his advice is there is bias and the results should not be trusted. This hasn’t gone down too well with the authors concerned. One of the groups where bias was ‘detected’ suggested that, rather than using the statistics that he did, he could have just asked if there were any other studies that didn’t work out, and in their case they could demonstrate there wasn’t a problem (Galak & Meyvis, 2012). Another author, Uri Simonsohn from the University of Pennsylvania, takes Francis to task showing that, statistically, his own methods are highly biased (Simonsohn, 2012).

Simonsohn himself has been one of the key figures in uncovering research fraud which hasn’t been dependent on insiders ‘blowing the whistle’. His work led to the re-designation of Dirk Smeetsters from Erasmus University amid ‘serious questions about his work’. Since then, many of his papers have been ‘retracted’.

Retraction of papers is the mechanism for undoing some of the damage which publication of fraudulent results creates by making a public statement about the data and the nature of the fraud. A group which has a slightly campaigning feel to it, called Retractionwatch (http://retractionwatch.wordpress.com) was established in 2010 and it is worth quoting the first paragraph of the first entry of the blog by Ivan Oransky and Adam Marcus which is an example of the tone of their work:

*The unfolding drama of Anil Potti – a Duke researcher who posed as a Rhodes Scholar and appears to have invented key statistical analyses in a study of how breast cancer responds to chemotherapy – has sent ripples of angst through the cancer community. Potti’s antics prompted editors of *The Lancet Oncology* to issue an ‘expression of concern’ – a Britishism that might be better expressed as ‘Holy Shit!’ – about the validity of a 2007 paper in their journal by Potti and others.*

Since then, they have made it their business to monitor the retractions and also to comment on whether journals are as active as they should be in retracting dubious work. They have called for a ‘transparency index’ a bit like the impact factor journals publish, which would be an indication of the journal’s commitment to honest work.

As you can see from the above, the problem in psychology is important and being debated and researched in an interesting way. In November 2012, a detailed report was published on the conduct of Diederik Stapel entitled ‘Flawed science: The fraudulent research practices of social psychologist Diederik Stapel’ (the Levelt Committee, the Drenth Committee & the Noort Committee, 2012) which makes for some salutary reading as it discloses a problem with a research culture where it became
possible for fraudulent results to be generated under the eyes of three different universities. It reminded me as I was reading it of the report into the abusive career of Jimmy Savile (Gray & Watt, 2013).

The report followed on from an open e-mail from Daniel Kahneman which said concerning another field of psychological research (social priming) which has come under fierce scrutiny following fraud and academic misconduct: ‘…right or wrong, your field is now the poster child for doubts about the integrity of psychological research’. He went on to say:

My reason for writing this letter is that I see a train wreck looming. I expect the first victims to be young people on the job market. Being associated with a controversial and suspicious field will put them at a severe disadvantage in the competition for positions.

Most of the psychology referred to above concerns social or experimental psychology; clinical has so far not come under the spotlight to the same degree. However, as noted in an earlier column, there is some evidence that psychotherapy research may have some problems (Jopling, 2008).

The problems are not by any means limited to psychology and one particularly worrying area for clinical psychology is described in a number of books concerning medical research, particularly that connected with the pharmaceutical industry, which has some extraordinary problems (Goldacre, 2012).

Space precludes a more detailed look at this emerging story, but I hope this will have provided a useful introduction.

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References
I WILL BEGIN this article about professional ethics and the Francis report with my own views about the root causes of poor standards of care. I have a social model (see, for example, Oliver, 2013; Wolfensberger, 1972) that is similar in some ways to the Francis inquiry’s, but with some differences (Francis, 2013). Francis, particularly Volume 3, was very close to the mark, when he reports that the culture of an organisation is a key issue, but I think he underplays the wider picture of the overall culture (including power relationships) in which we live and how organisations tend to reflect that wider context – one in which some groups and individuals are subject to powerful forces of social devaluation. This is then manifested in different ways, including poor standards of care. The inquiry notes:

One true measure of the NHS’s effectiveness in delivering hospital care can be found in how well the elderly are looked after. They are a vulnerable group, often unable to assert their rights and legitimate expectations for themselves, and have complex needs. It is a measure not just of our health service but also of our civilisation as a society. (p.1595)

This expresses something of this wider context, but maybe misses the point that even civilised societies will have these devaluing forces at play, placing people at risk. These are essentially moral questions and our professional ethical principles and standards can be one route for ensuring these vulnerable groups are protected.

My personal experience in evaluating service quality

My learning about these ‘root causes’ of poor care, and indeed my interest in professional ethics, goes back to the 1980s when I was involved in using a service evaluation instrument, Program Analysis of Service Systems (PASS) based on normalisation/social role valorisation (SRV) principles (Wolfensberger, 1972, 1991; Wolfensberger & Thomas, 1983) We were using this as a training tool, in which a group of participants would be taught the basic idea that groups and individuals could suffer serious harm through social devaluation and that by the same token could be protected against this by occupying valued social roles (Wolfensberger, 1991). Participants then spent some time in a care setting and rated the quality of its care against 50 standards, the majority derived from SRV theory. During these evaluations we would get to know one or two of the people using the service, and try and get a feeling for what life was like for them. The majority of settings were institutions for people with learning difficulties or mental health problems, or for older adults, and in general the overall picture was not at all positive. What we experienced on the visit to the care setting was very powerful as it had the effect of ‘unveiling’ our usual percep-
tions and allowed us to view it through this social lens of devaluation. Two experiences come to mind as illustrations.

In one setting for older people, I sat down next to a few people who were in a room that was like an expanded part of the corridor. It was very quiet except for the ticking of the clock. I sat there for about an hour. During this time the things that took place have stayed with me. Every so often there would be the sound of footsteps and then the door would burst open and a staff member would walk in and brightly say a collective hello to everyone and then disappear through the other door and after this brief burst of noise it went back to the clock ticking. The only other event during this hour was when a woman was helped in by a staff member and sat down. Her handbag was placed in a chair out of reach. The staff member left. This clearly distressed the resident. She repeatedly called out for her bag, but nothing was done. I remain guilty for not fetching her bag, but at the time was trying to experience the life they had. Eventually I did fetch it, and then left the setting.

My second memory concerns a learning disability residential setting on bonfire night. There were no fireworks for the young people who lived there, but they (and we the visitors) all stood in the back garden trying to peer through a very thick hedge to see the village celebrations. It was very sad that they were separated in this way.

I have to say that I saw many much worse examples of care, but the above have remained with me as, while they were not as graphic, they are just the day-to-day devaluations that people in these groups experience. The SRV account of how these things happen makes good sense to me.

In another role as part of visiting teams with the Commission for Health Improvement and the Healthcare Commission (Commission for Health Improvement, n.d.) in the 2000s, going to mainly large general hospitals I similarly witnessed (in addition to excellent care) some very poor care, particularly on older people’s wards. I recall one staff member saying to me that the decor didn’t really matter, as the patients were ‘past their sell by date’. The reports we wrote laid the responsibility for this largely at the door of the Trust boards for not getting it right, and this, in some cases, resulted in the resignation of senior staff. While I had some hope that standards might improve as a result, I was much less confident in this analysis than in the one provided by SRV. Wolfensberger’s own recommended approach to dealing with poor care that people may experience in hospital is for individuals to voluntarily give their time to support and advocate for those they care about rather than hoping that government agencies will do this (Kendrick, 2007; Wolfensberger, 1992).

These societal processes of social devaluation have, of course, psychological aspects, and Mike Bender and I summarised some of these individual responses to people at risk of devaluation in a paper about dementia care: ‘So sad to see good care go bad – but is it surprising?’ (Bender & Wainwright, 2003). We wanted to make the point that it is likely that groups with these devalued identities will remain at risk and that it is not surprising that bad things happen to them. The research we quoted was from the social psychology literature (Asch, 1956; Festinger & Carlsmith, 1959; Milgram, 1974) to illustrate that the way we behave could best be understood as part of a much wider social framework. More recent studies of how we develop ethical blind spots are well described in Bazerman and Tenbrunsel’s work from the field of behavioural ethics as applied in a business context, which focuses more on, for example, cognitive biases (Bazerman & Tenbrunsel, 2011a, 2011b).

Organisational culture
Another important contextual strand that the inquiry noted was the presence of a bullying and intimidating culture that they said needs to be challenged. My reading of this, and from other points made in the report, is that there is a widespread problem of unethical behaviour among senior managers, arising from
their being put in positions where they feel pressured to cut corners to fulfil contractual targets. The consequence has been toxic work environments where bullying and intimidation are not uncommon.

On 14 February 2014 in *The Times*, Robert Francis said: ‘A repeat of the Stafford Hospital scandal is still possible and it is “dangerous” for NHS staff to think otherwise’, and warned that health chiefs are still ‘bullying’ hospitals to hit financial targets at the expense of patient care, and says that ‘hospitals trying to put patients first will soon be deterred if behaviour like this is not stopped’ (Francis, 2014b).

That this is indeed a problem has been acknowledged for some time (see for example research on training of medical staff (Paice & Smith, 2009).

Sir Ian Kennedy is another outspoken critic in this area. When Chair of the Healthcare Commission, he stated that: ‘A bullying culture in the NHS is permeating the delivery of care... One thing that worries me more than anything else in the NHS is bullying’ (Santry, 2009).

This issue is one where ethics can quickly become compromised – indeed, bullying itself is unethical. It leads to people being fearful of acting in a way that is in conflict with their management colleagues, and to whistleblowing becoming the only option. As a follow on to the Mid Staffordshire inquiry, Robert Francis is now chairing the *Freedom to Speak Up Review* (Francis, 2014a), described as an independent review into creating an open and honest reporting culture in the NHS. The aim is that: ‘Those who speak up when things go wrong in the NHS should be welcomed for the contribution they can make to patient safety.’

It is a commentary on all the previous initiatives and their surrounding rhetoric that this is still needed, and leads me to return to the point that wider social and political forces are at play that need to be addressed.

**Professional codes of ethics and conduct, clinical psychology and management**

So how can we link this context of culture and values to professional ethics and in particular the British Psychological Society’s (BPS) *Code of Ethics and Conduct*? In the introduction to the Inquiry a central concern is indeed compliance with professional codes of ethics and conduct. Francis says of the role of the professions and their compliance with their own professional standards:

> As has been frequently pointed out to the inquiry, the primary responsibility for allowing standards at an acute hospital trust to become unacceptable must lie with its Board, and the Trust’s professional staff. The system is designed for directors to lead and manage the provision of services within its allocated budget but in accordance with required standards, and for professional staff, informed by their ethical standards and commitment, to serve and protect their patients. If every board succeeded in that challenging task, and if all professional staff complied at all times with the ethics of their professions, there would have been no need for the plethora of organisations with commissioning and performance management responsibilities. (Page 14, Part 1, Introduction – emphasis added).

As professional psychologists this asks us to consider why we might not comply at all times with the ethics of our profession. It also has implications for the function of the Society. In the current regulatory framework, how does the BPS act to support its members complying? In what way could it enhance its current role to promote an ethical culture in which professional staff working to their codes of ethics and conduct would be actively promoted by the organisation, with a strong focus on putting the patient first, as Francis argues in the above quote.

In many Trusts, professional leadership has been weakened over the past few years. Perhaps the time has come to use the opportunity created by the inquiry to review this, and for the DCP (and the Leadership and Management Faculty in particular) to link its strategy for strengthening local professional leadership to the promotion of an ethical culture within the NHS.

This could be linked to another recommendation in the inquiry: that all managers should be signed up to a code of ethics, and perhaps we could see a joint project of sup-
porting managers and clinicians in complying with these principles. The use of codes of ethics is now widespread and the evidence generally support their use (Center for the Study of Ethics in the Professions, 2013).

This recommendation fits well with the work of Professor Derek Mowbray, clinical and organisational psychologist, who has consistently argued that implementing a management code is badly needed and that it is primarily this implementation aspect that is the problem. He produced a *Code for Managers* (Mowbray, 2014) which has now been incorporated into the Institute of Healthcare Management Code and was formally adopted in January 2012. An excellent presentation outlining the rationale for the code and its purpose is given in a presentation by Dame Carol Black (Black, 2012), Expert Adviser on Health and Work at the Department of Health, at its launch. At the end of her talk the last slide says: ‘Please use the code’. Clearly, unless the code is used it will not have much impact, and implementation is going to be key here.

Another body that has taken this on is the Professional Standards Authority – the regulator of regulators. They have published a code which sets out standards for members of NHS boards and clinical commissioning groups – the governing bodies in England (Professional Standards Authority, 2013).

It sets out the following principles for managers and they have a familiar ring, being very similar to the Society’s *Code of Ethics and Conduct*:

- responsibility;
- honesty;
- openness;
- respect;
- professionalism;
- leadership; and
- integrity.

I have not been able to clarify the mechanism for these codes to be implemented or how managers may be held to account. Whatever emerges in that context, however, we have a golden opportunity for collaboration between our own professional body (whether the DCP or the Society) to make the NHS a thoroughly ethical place to work and deliver services. Such codes, backed by professional bodies like the DCP and the Institute of Healthcare Management, provide a possible way to resist unethical political demands. It would suggest that now would be a good time for the cultivation of ethical communities in NHS organisations across all professional groups, including managers, who are often put in situations where their ethical standards can be compromised.

**Implementation**

This special issue could be a game changer in how the DCP links practice to action, as the inquiry gives us permission to intervene as professionals in the cultural landscape of health and welfare which may have hitherto appeared to be too political for us as a professional body. Francis is very clear: we have an ethical duty to act and this may mean taking on powerful vested interests and societal value systems if we are to have any real impact on quality of care.

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AS A PRACTISING consultant child and adolescent psychiatrist and active member of the critical psychiatry network, I am aware that there are many ethical dimensions embedded in the ‘first do no harm’ Hippocratic Oath that doctors and health care professionals are expected to abide by. Here, I consider the impact of our decisions well beyond our professional self-interest: from how what we do may harm patients, to potential harms wrought by our beliefs and practices in the cultural milieu at large.

Psychologists and psychiatrists, along with psychotherapists and other allied professionals, work in contested territories. The arena of mental health is dominated by uncertainties. We are influenced by diverse factors that span the panoply of ‘what makes us human’, including our biology, psychology, social circumstances, cultural experiences, politics, and so on. In recent decades psychiatrists and psychologists have sometimes found themselves in dispute about which profession has a better grasp and understanding of what is happening when this human experience is disrupted, to a point where professional assistance is needed. However, a step back from this interprofessional rivalry suggests, to me at least, that more importance lies in an examination of the ideas and meaning-making frameworks we use, rather than our assumptions about intraprofessional ideologies. Here it is possible to identify different ‘community of interests’ which have emerged that join particular psychologists and psychiatrists together in either supporting current hegemonic beliefs, practices and service structures (often referred to as the ‘medical model’) or critiquing it and favouring more psychosocially and relationally orientated models.

One such community of interest is reflected in recent high profile publications. An article authored by 29 members of the Royal College of Psychiatrists in the British Journal of Psychiatry argued that the evidence base points toward the need for an important paradigm shift in practice away from the technically-based medical model toward the primacy of contexts, meanings and ethics (Bracken et al., 2012). At a similar time and independently, a group of psychologists published, in response to the mounting concern about the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), an influential position statement challenging the basis of medical model diagnosis driven thinking (Division of Clinical Psychology, 2013). Many of the psychologists and psychiatrists in these two groups are now working together to promote debate within their professions and more widely on the evidence and ethics of current practice models and urging the widespread adoption of alternatives to the medical model.

The arguments note that the evidence-base finds little scientific support for the current approach to organising practice and services. The belief that our subjectively constructed diagnostic frameworks help us...
choose a technically specific intervention is now being shown to be based more on wishful thinking than the findings of good outcome studies. The belief that treatments for mental health problems resemble giving insulin for diabetes is quite simply wrong.

For example, take the most commonly made diagnosis in mental health – that of depression. Available evidence does not support the idea that depression is caused by any chemical imbalance; anti-depressants appear to create rather than ameliorate a chemical imbalance (Moncrieff, 2008). Indeed, despite having important psychoactive properties, meta-analyses of drug treatments for depression demonstrate minimal differences between drugs and placebos (Kirsch et al., 2008). The other physical treatment used sometimes, that of electroconvulsive therapy (ECT), has a similarly poor evidence base, with reviews of studies comparing real with ‘sham’ ECT, highlighting the importance of non-technical aspects of treatment. The most recent systematic review did not find a significant difference between real and sham ECT after the treatment period (Read & Bentall, 2010).

A similar lack of specificity emerges from the literature on psychotherapy. Cognitive behavioural therapy (CBT), the form of psychotherapy most widely promoted today, is premised on the idea that rectifying faulty cognitions in depression leads to recovery. However, several studies have shown that most of the specific features of CBT can be dropped without adversely affecting outcomes (Jacobson et al., 1996). The evidence that non-specific factors, as opposed to specific techniques, account for nearly all the change in therapy is overwhelming. Extra-therapeutic factors and the impact of the therapeutic relationship accounts for nearly all the variance in outcomes across the psychotherapy field, with matching therapeutic modality to diagnosis having a clinically insignificant impact on outcomes (Wampold, 2001; Cooper, 2008).

Why is this knowledge not known about or in the public consciousness? How far are our professions complicit in maintaining concepts and practices that are not compatible with the evidence? How ethical is it to avoid engagement with these vital questions and carry on doing what we do just because it is what we have always done? How much of this intellectual malaise is due to putting professional self-interest above patients’ best interests?

Both the professions of psychology and psychiatry are complicit in largely avoiding these questions of ethics and science. For example:

- How often do we lie about the current state of knowledge? (e.g. stating there is a chemical imbalance to justify recommending medication or suggesting that a particular form of therapy has superior outcomes to another).
- What are the consequences on individuals of our preferred framework for making sense of their dilemmas and struggles (e.g. the impact of telling someone they have a potentially lifelong disorder or using diagnosis as an explanation without producing any independent evidence demonstrating what is wrong with them psychologically or physiologically)?
- What impact will selling the technical model have in people’s lives outside the consulting room (e.g. keeping them at a school that is unsupportive through using medication, or the potential for stigma, discrimination and reduced life chances that accrue from carrying a psychiatric diagnosis)?
- Should we contribute to detaching subjective experiences of distress from real life events that have and maybe continue to happen in their lives (e.g. diagnoses like attention deficit hyperactivity disorder and autism rely on categorising outward behaviours that may obscure experiences of trauma, alienation and broader relationship difficulties; in other words, more context-based meanings)?

At the local social level we can also interrogate current practice for important practice and ethical dilemmas. What impact does our practice have in local communities? For example, will having one child apparently calm from medication spur more referrals
from that school and more children considered needing medication? Or what happens to the self-belief of parents and teachers in their ability to confidently and competently raise children when surrounded by messages that experts ‘know’ better? These local social dynamics also reflect and are reflected on by our cultural common sense that has come to accept that the diagnoses we use reflect some naturally occurring logical categories for which there are specific technical interventions. What does this professionalising of the vagaries of human experience have on our cultural models of childhood, family life and emotional experience? To what degrees are our models culturally specific (e.g. technical, individualistic, commodified)? At the political level, how far are human rights issues rendered invisible? How far are economic outcomes turned into medicalised individual failings, where socioeconomic oppression gets read as failures of the mind? It is worth recalling that a major spur for developing the Improving Access to Psychological Therapies (IAPT) project was the belief that depression causes unemployment and providing CBT to treat depression will lead to improved employment levels.

The above are just a small sample of the type of ethical dilemmas haunting the scientifically failed enterprise of trying to categorise human mental suffering and behavioural variation into decontextualised intra-individual technical processes. According to many, the harms already perpetrated by well-meaning attempts to help is already catastrophic for those who end up being diagnosed as having chronic mental illness. The outcomes for this group are frightening. Increasing numbers are falling into this category, and rates of long-term recovery are getting worse, not better. This group face a likelihood of dying some 15–20 years younger than the rest of the population. An increasing number of people are on disability benefits for a mental health reason, with over half of in receipt of this because of ‘depression’. There is an increase in use of both medication and psychological therapies, with little evidence that this is leading to any improvement in their long-term outcomes. It is hard to imagine such a record of harms could be tolerated in any other branch of healthcare, and it is hard to imagine how an ethical perspective can tolerate our use of the failed medical model diagnostic paradigm in mental health care any longer. It is time to reach beyond diagnostic dependence, to embrace models that prioritise meanings, contexts and values, with service users’ voices and a recovery orientation central. It’s what the scientific evidence and a ‘first do no harm’ ethical perspective says we should do.

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Over the past two years, I have been working on a self-help manual for older people with memory difficulties (Bender, 2013). Linking up with psychologists and others in the field has made me increasingly concerned about the role of psychologists in the field of dementia, especially in memory assessment clinics, and the ethical issues such work now raises.

A number of authors, such as Moncrieff (2009) and Whitaker (2010), have suggested that the drug companies use a common narrative with which to explain ‘emotional distress’ and convert its various manifestations into diagnosable ‘mental illnesses’. In this paper, I wish to: examine how this narrative has been used to define the field of cognitive impairment in old age; show how the narrative’s claims are seriously flawed; and look at the ethical implications for psychologists working with older people.

The major tenets of this dominant narrative include that all mental and emotional distress can be understood as specific mental illnesses. These mental illnesses are primarily organic processes. Because of their neurological basis, they are responsive to drugs; or in time, will be. Advances in pharmacotherapy are inevitable because of the heavy investment in research by the companies.

It is important to recognise the role of stakeholders – such as large charities, universities and their research staff, construction firms, and medical insurance – in the maintenance and strengthening of the narrative by, for example, their access to the media. We need to get away from focusing only on ‘big pharma’, as this masks the complexity of the dynamics and the process (and also has a defusing, childish, school playground ring about it).

The narrative applied to cognitive losses in old age

The narrative states that:

- There is a disease called ‘dementia’ – or more exactly, a group of diseases.
- Memory changes in old age are very largely caused by the onset of ‘dementia’.
- The changes in the brain causing dementia are now sufficiently understood to allow the development of appropriate medicines.
- Because the population is aging, we are in the middle of an epidemic of dementia.
- To be given a diagnosis of dementia is a catastrophe, for the person will inevitably become totally incompetent (and incontinent).

In the late nineties, the drug companies had launched their ‘cognitive enhancers’ – Aricept, Reminyl, etc. – with huge advertising budgets to support the claims that:

- These drugs are pretty effective and, within a short time, newer drugs will
come on the market which will be even more effective.

- Therefore, given these benefits, all older people with memory difficulties should be seen quickly and given an assessment by a memory service.
- It is implied that there are no economic or psychological costs to the person being assessed.
- Since pharmacological developments represent the way forward, there is little point in spending money on researching psychological models of what ‘dementia’ is and relevant processes, or in developing appropriate psychotherapeutic methods.

As outlined above, this narrative was augmented by other stakeholders. ‘Dementia’ was and is being demonised. Adverts by the Alzheimer’s Society and other charities showed people wearing pyjamas out in public, or disappearing into thin air, portraying the state of dementia as relating to non-persons (Bender et al., 2002).

**The reality situation**

**Dementia as an understood disease**

Alzheimer’s, we are told endlessly, is caused by excess plaques and neurofibrillary tangles. However, the brains of ‘normal’ older people contain many plaques and fibrules, to such an extent that there is considerable overlap with the brains of people diagnosed with ‘dementia’ (Kitwood, 1997). This makes it unclear whether ‘dementia’ is the normal condition of an ageing brain, or an actual disease. Certainly, David Snowdon, in *Aging with Grace*, a study of nuns who agreed to a brain autopsy on their death, found nuns whose brains had very high levels of plaques and fibrules, functioning highly competently.

The most remarkable piece of data that does not fit this ‘paradigm’ is from the work of Dale Schenk (2012). Schenk was very innovative in managing to get enough of a vaccine to pass through the brain barrier to remove all plaque growth in genetically modified mice. The trials on humans suffering from Alzheimer’s were stopped because a percentage of the human guinea pigs developed brain inflammation. But before they were, it became clear that ‘the vaccine appeared to be very effective in removing amyloid from the brain of patients with Alzheimer’s, but those patients showed no sign of clinical improvements’ (Waldman & Lamb, 2004, p.255).

Waldman and Lamb also provide quite compelling evidence that ‘rapid’ Alzheimer’s – which should not happen in a slowly progressing disease – is probably caused by a prion.

‘Vascular dementia’ concerns cerebral vascular events or strokes. The average diet today is loaded with sugar and saturated fats, which are strongly linked to heart attacks and strokes. Research has consistently shown an elevated rate of later dementia among those overweight in middle age (Naderali et al., 2009). For example, Whitmer et al. (2005) give increased rates of later dementia of 75 per cent in the obese and 35 per cent among the overweight. With one third of the nation obese, it is actively misleading to put the increase in rates of dementia solely down to an ageing population. A report by a team of experts led by David Le Couteur, professor of Geriatric Medicine at the University of Sydney, concluded ‘...the political rhetoric expended on preventing the burden of dementia would be much better served by efforts to reduce smoking and obesity, given current knowledge linking mid-life obesity and cigarettes’ (*The Psychologist*, November 2013, p.787).

In short, the scientific basis of the organic narrative of ‘dementia illness’ is open to serious question.

**The drug cure**

The newer drugs are of use only with Alzheimer’s disease, not with vascular or Lewy body dementia, so were always going to have a restricted range of utility in any event. In a recent review of the evidence in *Dementia for Hospital Physicians*, Harwood (2012) concluded that:

> Cholinesterase inhibitors improve cognition and function in Alzheimer’s disease by a small amount (one MMSE (Mini-Mental State Examination) point on average), but about 15 per cent are super-responders (improving four of more MMSE points). (p.39)
The ethics of complicity?

This might sound like good news if you were one of the fifteen per cent, but improvement on the MMSE is what Goldacre (2012) calls ‘soft data’ – while it is convenient to gather, it does not actually measure the state of the condition. Remembering who the Prime Minister is may bear no relationship to whether you can find your way home from the local shops. Le Couteur and his colleagues, in the report described in The Psychologist, is more critical regarding cholinesterase inhibitors: ‘unsupported remedies... linked with increased risks of falls and fainting’, events which can have very serious consequences for the older person.

Early assessment and diagnosis are self-evidently beneficial
Brunet (2013) pointed out that there is no evidence to indicate that early diagnosis affects the rate of progression or prevents crises. Additionally, as Iliffe (2013) points out:

One possible risk for some is that an early diagnosis will force individuals onto an escalator of disability. (p.5)

It seems likely that some family members will react in this manner towards the sufferer.

At the most basic level, the ‘no or low cost’ of diagnosis is not credible. The person so diagnosed has a legal requirement to report themselves to the DVLA at Swansea; and one can hardly deny the stigma of being diagnosed as having ‘dementia’.

There is a basic lack of support for people who are worried they may have dementia. People with HIV/AIDS or seeking terminations are routinely offered counselling, both before and after the diagnostic tests. Clinical psychologists are pushing for prediagnostic counselling, mentoring during the assessment, and post-diagnostic counselling; but progress has been uneven.

The inevitable advance of science
David Shenk in his The Forgetting: A Biography of a disease, writes of attending the ‘Molecular Mechanisms’ conference in 2007, in Taos, New Mexico, along with a ‘scientific elite’ of some 200 delegates:

‘An important subtext...’ he [one scientist] whispered in the middle of a presentation ‘is that all of these scientists have patents on their discoveries. There’s a lot of money at stake.’ (p.157).

Another can only tell his audience ‘We’re very close to the goal line now’ [He] turned to me and said, ‘This was one of the most frustrating experiences I’ve ever had in my life: to speak to a group like this and not tell them what I know.’ (p.159)

This commercialisation of science requires that the product is presented in the most favourable light. Methods of achieving this are discussed at length by Goldacre (2009, 2012). For example, non-reporting of subgroups that show no benefit and massaging of data ensure that positive results are highlighted and negative ones minimised. What is noticeable is that, while these processes are discussed in the American literature, there is no equivalent public debate about the identical process going on in this country. Whatever the rationalisations, the scientific process whereby the sum is greater than its parts, through reciprocal encouragement, sharing of data, and development of ideas, has been stunted, if not destroyed. These processes also reduce the credibility of initial drug trials, so that the claim ‘x is an improved anti-psychotic’, despite the scientific trappings, has the same status as ‘probably the best lager in the world’.

Where does this leave clinical psychologists working with older people?
Clinical psychologists have had a long training in research methods at both undergraduate and graduate levels. They are therefore well placed to comment on poor scientific practices, but have seemed reluctant to do so.

Conversations with colleagues suggest that their ability to act as applied practitioners in their place of work to develop their understanding by undertaking research appears to have been lost, or very severely restricted.

It is perhaps the psychologist working in a Memory Assessment Service, which provides little or no follow-up services, who is in the most difficult situation. They have put the
person through a potentially stressful and stigmatising process with definite losses and little or no apparent gains. If the psychologist is not permitted to offer therapeutic interventions, their role is purely diagnostic. But surely the most important and relevant skill of the clinical psychologist is an individual case formulation (Hallam, 2013)? If such interventions are relevant and useful, doesn’t the clinical psychologist have a responsibility to offer them to their clients? Don’t they also have a responsibility to develop effective therapeutic techniques, be they individual, couple or familial?

Since the pressures on their professionalism are unlikely to go away, Large’s (2013, p.46) comment: ‘we are the only listening profession that does not mandate personal therapy as part of our training courses’ is pertinent, as is the question as to whether clinical psychologists would not benefit from such a resource throughout their careers.

With the lack of services, and with professionals apparently not in a position to help them, what can people with ‘dementia’ do? If they want any quality of life, they will have to move from being passive recipients of medical services to becoming active agents. Consequently, I felt that starting a pressure group had to be a key feature of the self-help manual I wrote for people diagnosed with early stage dementia (Bender, 2013). If sufferers and relatives are going to campaign for the appropriate range and quality of services then should not health professionals, including clinical psychologists, be alongside them in these efforts? Or will they be silent, thinking ‘more than my job’s worth’, a fear that management will be happy to reinforce.

This fear can be combated, at least in part, if psychologists use the power of the group. The more I researched this area, the more I saw the importance of group support as an active ingredient to well-being, for both the sufferer and the clinical psychologist. Sadly, psychologists have traditionally been very unwilling to stand up together and for each other.

The awareness of group strength needs to be acted on through a series of nested networks. I am impressed by the Frontline First website (http://frontlinefirst.rcn.org.uk), hosted by the Royal College of Nursing, where nurses can anonymously voice their concerns about service cuts and developments. It offers a ‘whistleblowers’ hotline’. I have not been able to find any equivalent initiative by the British Psychological Society, but it would seem equally, if not more, necessary for clinical psychologists, and could be developed by the Division, acting independently if required.

The present Care Quality Commission (CQC) chief executive, David Behan, has campaigned for a legal duty of candour and wishes the CQC to actively seek out and listen to whistle blowers (Nursing Week News, 23 October 2013, p.5), so seeking change may be timely.

To break free from a flawed and inauthentic narrative, clinical psychologists will need to develop support systems. They need to move away from seeing themselves as powerless to learning how to work collaboratively and reap the benefit in terms of creativity, flexibility of service and (decreased?) freedom from a bullying management setting non-relevant targets. But before this can happen, they need to stop denying and suppressing the contradictions and the inadequacy of the services being offered to older people with cognitive difficulties. They have to stop denying that to work in clinical psychology today is to be frequently faced with ethical dilemmas – dilemmas that require an active response by themselves working collaboratively with their colleagues locally and across the whole profession throughout the United Kingdom.

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References
Ethics and the profession's relationship to diagnosis and psychiatric treatment

What's the problem with classification?

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Tony Wainwright

Ethical problems lurk in the most unlikely areas. Take classification for example. (see Wainwright 2010). I first came across the wonders of this area from my early interests in the natural sciences – zoology, botany, geology and the like. All of these made immense strides when recording and classification systems were developed.

It is arguably the case that Charles Darwin would not have been able to construct his theory of evolution without the preceding work of the data gatherers and classifiers who went before him. In particular there was one extraordinary Swedish scientist, Carl Linnaeus, whose work, Systema Naturae (its full title was ‘System of nature through the three kingdoms of nature, according to classes, orders, genera and species, with characters, differences, synonyms, places’) revolutionised natural history by developing a systematic classification of the natural world, turning it from an art to a science.

A less well known, and rather less cheery, aspect of his work was that he also was founder of the science of races in the human species, classified on physical characteristics like skin colour, used by racist ideologies ever since, Lifton (1986) for discussion.

Linnaeus also applied his classification methods to the mind, dividing mental problems into: Ideales (dilireaum, amentia, mania, melancholia and vesania), Imaginarii (hypochondria, phobia, somnambulism and vertigo) and Patheci (bulimia polydypsia, satyriasis and erotomania). The earliest records of such systems can be dated to the Greek physician, Hippocrates (4th century BC) who coined the terms ‘phrenesis’, ‘mania’ and ‘melancholia’, versions of which were built on and developed over the centuries.

From Linnaeus it was only a short step to the work of the 19th century German Emil Kraepelin, whose Handbook of Psychiatry set out effectively the theoretical basis for modern mental health systems. Alongside this was the classification of those with intellectual disabilities. The language is so offensive now it is hard to credit that these were regarded as reasonable terms: ‘idiot’, ‘moron’, ‘imbecile’, ‘feeble-minded’, to name a few (Goddard, 1912).

The ethics of classification and language use emerged in force at last year’s Division of Clinical Psychology Annual Conference, held in Manchester in December. It concerned the invitation given to Professor Ken Zucker to provide a keynote presentation. His work on children and teenagers who are distressed and confused by their assigned gender has been and remains highly contentious. There were at least two issues here. The first concerned freedom of speech, academic freedom and similar concerns related to whether the Division of Clinical Psychology should have invited him in the first place and whether the Division of Clinical Psychology should have withdrawn his invitation having come to realise the controversial nature of his work. The second, and...
What's the problem with classification?

This is the theme of this column, concerned whether classifying children as suffering from 'gender identity disorder' (GID) can be considered ethical.

Outside the conference there was a demonstration of people opposed to his work. A Facebook page was set up to coordinate people’s views and to organise attendance.

On the question of the ethics of his work, a brief description is needed, as it may not be familiar to everyone. Professor Zucker, is psychologist-in-chief and head of the gender identity service in the child, youth, and family programme of the Center for Addiction and Mental Health in Toronto. He is also a professor with the departments of psychiatry and psychology at the University of Toronto. The title of this talk was ‘Gender identity disorder in children and adolescents: Towards DSM-5’. Professor Zucker, who is a clinical psychologist, is also chair of one of the groups working on the new version of the Diagnostic and Statistical Manual of the American Psychiatric Association.

The Center’s website describes his work as follows:

Dr Zucker studies psychosexual differentiation and its disorders in children and adolescents. In the Gender Identity Service at CAMH, he and his team of scientists conduct research on children and adolescents who meet the DSM criteria for gender identity disorder. This research focuses on diagnosis and assessment, associated psychopathology, causal mechanisms, and long-term follow-up. Dr. Zucker also studies psychosexual differentiation in infants, children, and adolescents born with a disorder of sex development (physical intersex condition) with colleagues at the Multidisciplinary Urological (MUG) Clinic at the Hospital for Sick Children. Their research includes systematic studies of specific disorders of sex development (DSD) conditions with regard to psychosexual and psychosocial adjustment.

As will be obvious, Professor Zucker is convinced that classification systems like DSM are very helpful. He would argue that psychiatric classification has delivered enormous benefits to people by allowing us to research particular conditions and arrive at treatments which are effective and relieve distress.

As a side issue, but rather worrying to me at any rate, was the fact that in his presentation he showed pictures of children he has worked with and described some of their clinical background. I would like to have known how informed consent was obtained to show these images, (or indeed to discuss their clinical problems), especially as some of the children were very young.

He said that while this was a ‘low incidence disorder’ the number of adolescents being referred to services like his has quadrupled in recent years. He made it clear that the work he does is, from his point of view, highly ethical, and meets the needs of distressed children, many of whom otherwise would continue to be distressed in adult life.

The Community Psychology Section, via its e-mail list, prepared a statement, some of which I reproduce here which indicates its view about his work:

The work of Dr Kenneth Zucker functions to undermine support for children’s own gender and gender-associated expression, is discriminatory against people whose own gender differs from their gender assignment (e.g. those often labelled ‘trans’ or ‘gender variant’) and inhibits the legal and social recognition of transgender individuals consistent with their gender identity and expression. The promotion of discourses which position children who self-identify as boys as ‘girls with gender identity disorder’ or self-identified girls as ‘boys with GID’ violates professional ethics which mandate psychological professionals to avoid causing harm.

In addition to problematic discriminatory discourses, problematic practices, including behavioural reorientation work with children, violate international human rights policies, including the United Nations Convention on the Rights of the Child (UNCRC) by interfering with children’s freedom of play and expression and by failing to provide children the opportunity to be heard and their views to be given due weight in relation to their experiences of their own gender and gender-associated expression. We regard deterring children from wearing clothes
associated with any gender, from playing with friends of any gender, or from engaging in play stereotypically associated with any gender as being oppressive.

We urge the British Psychological Society Division of Clinical Psychology and all psychological professionals to:

- support legal and social recognition of people of all ages in a manner consistent with their self-designated gender;
- protect the freedom of all children to play, dress, friendship, and expression associated with any gender;
- condemn behavioural reorientation work with children;
- boycott and protest psychological environments that support discriminatory and oppressive discourses and practices which functions to undermine support for children’s own gender and gender-associated expression, are discriminatory against people whose own gender differs from their gender assignment and inhibit the legal and social recognition of transgender individuals consistent with their gender identity and expression.

The Chair of the DCP, Jenny Taylor, and the conference organisers had correspondence with both the group of protestors, and also some internal BPS groups. Before Professor Zucker was introduced, Dr Taylor opened the session, explaining to the audience that the controversial nature of Professor Zucker’s work was not known to the DCP Executive Committee until it was brought to their attention by correspondence from Society members. On further consideration of Professor Zucker’s work, the committee came to the conclusion that it had been inappropriate to invite Professor Zucker as a single keynote speaker, and that, on becoming aware of the controversies in this field, the committee was of the opinion that such work would be most appropriately presented in the format of a debate or symposium, giving voice to the alternative views regarding classification of and treatment of gender variance.

The conference organisers therefore invited the groups who had contacted the DCP to join the session to provide alternative viewpoints, and also attempted to source additional speakers, but were unable to find anyone willing to join the session. The executive committee therefore made the decision to go ahead with the presentation, on the grounds that by so doing the DCP would be bringing to attendees’ attention the debates surrounding this field of clinical work, but to preface Professor Zucker’s presentation with a summary of the key ethical issues to be considered. In addition, two members of the group who were protesting outside were invited in to hear him and contribute to the debate which followed. I understand that all the presentations will be available on the conference website.

During the discussion the chair and incoming chair both made useful points. Dr Taylor (outgoing DCP Chair) queried whether the distress experienced by gender variant children (which provides the primary rationale for treatment) would exist if they did not experience social discrimination, and therefore queried the ethics of treating the individual rather than attempting to increase society’s understanding of the normality of a range of gender expression; and Professor Kinderman (the incoming DCP Chair) asked why, as a psychologist, when Professor Zucker has the opportunity to use a narrative of human rights and the psychological science of the development of human sexuality in all its variety, did he choose a narrative of disorder and illness?

As the reference to Linnaeus’ work on race above testifies, classification systems have a knack for getting things seriously wrong, as well as being wonderfully effective in organising information. And when it comes to classifying human characteristics, if you get it wrong, then serious harm can result. The point about classification systems is that they are a useful tool, but can easily become fixed and limiting. In Richard Bentall’s recent book Doctoring the Mind: Why psychiatric treatments fail, he discusses at some length these issues (see particularly chapter 5: ‘People or plants? The myth that psychiatric diagnoses are meaningful’). Professor Bentall also spoke at the conference on his research studies on paranoia. He is a scientist, and he is clear that people do have very troubling mental complaints (like paranoia) but
the classification systems surrounding them are flawed. After outlining the implications of the way psychiatric disorders are classified he has this to say in his book:

> Because of these enormous implications, it is important that any widely used system of psychiatric classification provides a realistic and meaningful framework for understanding the problems that patients bring to the clinic. If they do not, their utility in determining treatment must be suspect, research that makes the use of them is undermined, and the decisions made by health ministers and drug licensing authorities are exposed as arbitrary.

He follows this up with:

> My own view is that most psychiatric diagnoses are about as scientifically meaningful as star signs, a diagnostic system which is similarly used to describe people and predict what will happen to them, and which enjoys a wide following, despite compelling evidence that it is useless.

What are the ethical issues involved here?

■ Should the Society have a position on who it invites to speak at conferences where there is debate concerning the ethics of the work being undertaken. If so, who would be the judge? Would the practice of Professor Zucker be ethical when judged against the criteria in the Society’s Code of Conduct and Ethics?

■ What are the broader ethical issues emerging concerning the use of diagnosis in psychological practice? If they are, as Professor Bentall maintains, as scientific as star signs, it would be unethical to use them, or indeed, promote their use.

The BPS Ethics Committee will be considering these issues in a forthcoming meeting.

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References
IT WAS PROBABLY in 1980 or so when I was on placement in Sussex, doing my clinical psychology training, when I first came across electroconvulsive therapy (ECT) first hand. I remember being really interested in how the ECT service functioned and was impressed with the way it worked. People would arrive first thing in the morning, often with their husbands or wives, and come in to the waiting area, which was quite pleasant – all very medical, as I recall. They then went into the ECT suite and had their treatment, and then were wheeled into the recovery area, which is where I was doing my trainee thing. I would sit with people as they recovered and when they had come round from the anaesthetic, their memory had returned, would get them a drink and a biscuit and meet up again with their relative. Nurses were on hand to make sure everything worked smoothly. It was fascinating seeing people wake up from the anaesthetic with no clue who they were or where they were, and for this to gradually return over a few minutes.

In the outpatients I met people who were very keen to have ECT, and were regular users of it – real enthusiasts. They reported that their depression was so disabling and that they found the ECT so effective (if temporarily) that they said they didn’t know what they would do without it.

I also witnessed some serious problems with ECT when I was in training and subsequently. These were seen as largely about it being poorly administered, which was especially serious as a general anaesthetic was being given. This was such a problem that the Royal College of Psychiatrists conducted an audit (Pippard & Ellam, 1981) which reported disgraceful practice. This is reported to have significantly improved with the establishment of the Royal College’s ECT accreditation service.

And it was recently on the train that I picked up a discarded copy of the Daily Mail and was surprised to see a story headlined ‘As leading psychologists call for it to be banned... Should we still be using electric shock therapy for depression?’ (Hagan, 2011). The leading psychologists concerned were reported as being Dr Peter Kinderman, DCP Chair, and Dr Lucy Johnstone, DCP Press Officer. The report concerns a paper published last year by John Read and Richard Bentall that conducted a systematic review of the evidence for the effectiveness of electroconvulsive therapy (Read & Bentall, 2010). They concluded that:

Given the strong evidence (summarised here) of persistent and, for some, permanent brain dysfunction, primarily evidenced in the form of retrograde and anterograde amnesia, and the evidence of a slight but significant increased risk of death, the cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified.
The Daily Mail gave examples of celebrities who had benefited from ECT, but also included the following:

There is no evidence, the psychologists argue, that ECT reduces overall suicide rates in the deeply depressed.

Now the British Psychological Society wants an end to the use of what it describes as an ‘inhumane and degrading’ treatment.

Professor Peter Kinderman, a leading light in the organisation, says: ‘There is a myth that ECT is reserved purely for psychiatric emergencies.’ In fact, he says, ‘it is quite a common practice’.

Consultant clinical psychologist Lucy Johnstone adds: ‘There is no known mechanism by which ECT acts on depression, and little evidence that it is effective beyond the first four weeks.

The support group ECT Anonymous says patients often report major changes in personality after treatment.

Lucy Johnstone has a long track record in raising important issues about psychiatric treatment including Johnstone, 2000, 1999, 2003. Her research, cited in NICE guidelines, suggests that up to a third of people can experience ECT as extremely traumatic, and even, in the case of survivors of sexual abuse, as reabuse.

At approximately the same time in January 2011, the United States Food and Drug Administration (FDA) was to hold a Neurological Devices Advisory Panel to consider whether to downgrade the risk category for ECT devices.

The Psychologist news story on the BPS website, dated 9 February, had this about the review of ECT devices (tinyurl.com/5wyubfm):

Despite opposition from patient advocacy groups and some psychologists, the procedure remains popular among US psychiatrists, especially for patients with severe depression or schizophrenia who have shown no benefit from other treatments.

The American Psychiatric Association (APA) is lobbying for the risk level to be relaxed. ‘The safety of ECT when properly administered is well documented in the scientific literature and its effectiveness in treating severe mental illnesses is recognised by the American Psychiatric Association, the American Medical Association, and others in the United States and many other countries,’ the organisation claimed in an earlier statement. The New York Times reported in January that APA medical director and chief executive James Scully Jr. had also written personally to the FDA, claiming that ECT is effective 80 per cent of the time, and that there’s no evidence that it causes brain damage.

This view runs entirely contrary to evidence published in timely fashion by two clinical psychologists late last year in the journal Epidemiologiae Psichiatria Sociale (tinyurl.com/5tktsgh), and submitted to the FDA hearing. BPS Fellow Richard Bentall of the University of Bangor and John Read of the University of Auckland reviewed the findings from all studies over the last 60 years that compared ECT for depression or schizophrenia against a placebo control procedure. From the eight meta-analyses they located, Bentall and Read concluded that the benefits of ECT, in the rare cases they arise, are minimal, short-lived and come with the significant risk of memory impairment and a slight risk of death.

Peter Kinderman, chair of the Society’s Division of Clinical Psychology, welcomed the review. ‘Psychologists have long expressed serious reservations about the use of ECT, and this paper supports that position. People have a fundamental right to be protected from inhumane or degrading treatment.’

The decision the Neurological Devices Advisory Panel arrived at was to keep the ECT devices at the current (highest risk level). The implications of this are quite far reaching. According to a report in Internal Medicine News (tinyurl.com/4pbphhl):

Under the Medical Devices Amendments of 1976, class III devices require manufacturers to submit a premarket approval application (PMA), which includes clinical trial data, to
provide adequate evidence that the device is safe and effective for its intended use. But because ECT devices were on the market before 1976, they have been exempted from the approval process. Instead, ECT manufacturers have been required to show that the devices are substantially equivalent to a legally marketed device before they are cleared for marketing.

So I thought that this might provide a potentially useful case example of how clinical psychologists set about considering the ethics of physical treatments which they may not administer directly, but participate in though collaboration with teams delivering them. While this article is focused on ECT, it perhaps serves to remind us that we probably can’t ethically avoid the responsibility for considering the safety and effectiveness of the treatments which our colleagues are using.

So what could clinical psychologists do under these circumstances?

The first suggestion might be to turn to the Code of Ethics and Conduct. Section 3.1 states that psychologists should:

Avoid harming clients, but take into account that the interests of different clients may conflict. The psychologist will need to weigh these interests and the potential harm caused by alternative courses of action or inaction.

Given the material raised above, it would clearly be incumbent on any psychologist working in this area to:
1. Read the primary sources, and form a judgement for themselves.
2. Consider statements coming from our professional body expressing ‘serious reservations’ about the use of ECT and questioning the balance of benefit to risk of the procedure.
3. Review the information from the United States Neurological Devices Advisory Panel considering the risk levels noting that they took the view that there was insufficient evidence to justify downgrading the risk level, and may require further evidence.
4. Review Read and Bentall’s paper on the published research.
5. Review the NICE (2003) which carefully restrict its use, but does not go as far as would be recommended by those quoted above.

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COLLEAGUES who resist the principle of psychiatric diagnosis dwell largely on its scientific pitfalls and the lack of psychological adequacy implied by a categorical view of human thought and action (Pilgrim, 2009). At times this resistance includes an ethical sub-argument, especially in relation to the humanistic advantages of formulations providing richer contextualised accounts. Below I dwell on a further ethical matter, arising from reframing diagnosis. If mental disorder is to be depathologised and authentically put back into its personal and social context, then we are also obliged to deal with an elephant in the room. People who are deemed by those who are normal by common consent to be mentally disordered in a variety of ways are seen to be acting in an unreasonable way in particular contexts.

The term ‘mental disorder’ is vast and highly variegated, even though, socially, acquiring any psychiatric diagnosis may lead to crude stereotyping and stigmatisation from others: all ‘mental disorder’ may be lumped together in the prejudicial public imagination. At the same time, mental disorder is not unique in attracting these social processes of rejection and oppression. For example, epilepsy is highly stigmatised and many physical illnesses, such as tuberculosis, sexually transmitted diseases and even cancer, have been surrounded by a moral discourse of shame and exclusion (Scambler, 2004).

However, we can also take into account the extent to which the whole self is or is not implicated in different forms of disability. For example, one may have a broken back but one is mentally ill. We cannot neatly claim that mental disorders are uniquely different from physical disorders. But maybe we can say is that they arouse particular processes of fear and social distancing and possibly a disproportionate response to threat, real or imagined. Thus, once we open up mental disorder as a socio-ethical matter, we can appeal to the insights of sociology (especially labelling theory (Link, 2000)) and moral philosophy.

A useful starting point for our purposes from the latter is the emphasis placed by David Hume on our feelings or spontaneous ‘sentiments’ guiding normative judgements. Those with a physical impairment face a range of emotional reactions in others (especially pity, guilt, embarrassment and occasionally disgust). However, in the case of mental disorder, especially with the attribution of madness, that range of emotional reactions is different and tends much more towards fear and distrust (though depression and anxiety can invoke pity). These lead to dramatically different micro-social outcomes and political and social administrative consequences. The loss or lack of reason is at the centre of the social reaction typically evoked by mental health problems. For example, the demonstrated discrimination against people with physical disabilities has emerged in societies that have not adopted enabling policies to advance social inclusion. In the case of mental disorder,
social exclusion is actively justified on grounds of a lack of reason. A whole legislative apparatus is constructed to ensure and oversee that social exclusion. The policy is deemed to be socially progressive, to be exported from developed to developing countries (World Health Organization, 2005).

It is because people with mental health problems are deemed to be inherently unreasonable that others assume that they should be justifiably subjected to unequal treatment. Their rights to equal treatment are held in abeyance, until they are deemed less of a risk to themselves and others. This then leads to the acceptance of all of the coercive aspects of our mental health system as being politically warranted. This is an example of what Bourdieu (1977), following Aristotle, calls ‘doxa’, which refers to acculturated self-evident or unquestioned truths.

In our case, these ‘self-evident truths’ about unreason reflect a discourse of modernity and our post-Enlightenment normative expectations. In pre-modern times madness retained an ambiguous cultural quality, but since the 18th century it has been increasingly conceptualised as meaningless pathology, only worthy of containment and suppression. For example, the champion of free modern citizenship, J.S. Mill, insisted that children, idiots and lunatics were in need of care because of their ill-formed or lost reason. For antiquarian philosophers this was not always the case though. Socrates noted that madness was given by the gods and had virtuous as well problematic features. Sanity and madness were of equal value, which needed to be assessed in context, case by case. Socrates emphasised the virtues of mad rapture, the manic art of prophesying and the madness of poetic inspiration and romantic love (Screech, 1985). On the downside, then as now, madness was associated stereotypically with aimless wandering and violence (Rosen, 1968).

In modern times, Mayer (1985) notes that the recent history of social control is not merely about the State and its agents; ordinary people exercise their own forms of powerful informal labelling and control. The decision making about mental disorder occurs in the lay arena of the family (Coulter, 1973) and the street (Rogers, 1990), with professionals usually rubber-stamping decisions made already by significant others or the general public respectively. These normative judgements are not random but reflect context-specific expectations about rule-following and role success (in our complex post-industrial setting of late modernity). A failure of rule-role alignment may be judged in a particular context to be a reflection of mental disorder by others. Thus, in one sense to label others in these contexts is experienced as being ‘reasonable’ and demands that ‘something must be done’ likewise.

If we reframe forms of mental disorder then as socio-ethical challenges, we must address three main types of moral judgement. The first relates to intelligibility. If society is to work or ‘tick’ then social actors must not only conform to the expectation of others, but when the latter break down, then the deviant individual must give an account of themselves. Mad people break various rules but the most important transgression is that they break the latter ‘meta-rule’ of transparency or social accountability: they fail to render their peculiar or transgressive actions and speech intelligible, when required to do so by others (Goffman, 1959; Shotter, 1981).

In the second case, of ‘common mental health problems’, this matter of intelligibility and insight is less relevant (and hence the problem less ‘serious’). The moral focus is now then on distress. For example, the agoraphobic is highly aware and can explain their oddity to others, who are prepared to listen. But the outcome is still that the person fails in their adult roles (as a worker, shopper, parent, etc.). The third type of socio-ethical challenge refers to those disliked by others because of their recurrent self-centred conduct. Addictive problems and ‘personality disorders’ then reveal the socio-ethical challenge of incorrigibility.

These three forms of deviance historically reflect the aggregating social administrative role of what we currently call ‘mental health services’. First there was the focus on madness (the Victorian asylum system and lunacy laws). Then there was male distress as a social problem after the Great War (‘shell shock’). Then, after the 1930s, recklessness, personal dysfunc-
Mental disorder as a socio-ethical challenge

Mental disorder as a socio-ethical challenge became medical not moral problems. The ambit of psychiatry reflected these social administrative shifts. The medical profession certainly played a self-seeking role in their preferred jurisdiction (and still do – look at DSM-5), but they are not the whole answer. The general population also looked to psychiatry to deal with non-conformity, reverse common unhappiness and offer answers about burdensome or disagreeable people.

There is an overarching political and ethical matter implied by this triple re-framing, which is about social justice and moral consistency. Not all unreasonable action is socially disvalued or pathologised. For example, ‘narcissistic personality disorder’ might be a description of a patient or a politician taking us into an illegal war. A ‘psychopath’ might be in a secure facility or running a bank (Babiak & Hare, 2000). Moreover, it is not risk that is at issue here but the manner in which one is risky (Szasz, 1963) and a current example can be given.

We could invent a curfew law to ban under-30s from the streets from Friday dusk to Monday sunrise. It would massively reduce the risk of road traffic accidents, A&E attendance, domestic violence, unwanted pregnancies and sexual assaults (to name but a few). Why does the Mental Health Act exist but this law does not? Unprotected sex and smoking do not lead to people being locked up without trial, but fears about the unpredictable implications of hearing voices or holding strange beliefs can, and do, lead to this outcome. We do not habitually reflect on this ethical inconsistency.

If professionals and lay people are to deal with the question of natural justice then there is a collective opportunity to address questions raised above about why we respond to some risky people tolerantly and others dismissively or even coercively. This raises the matter of our current collective ‘wilful blindness’ about these matters. In exchange for the disadvantages of stigma and sometimes loss of liberty, professionals take away critical reflection and responsibility from others about social crises in everyday settings involving distressed, distressing or perplexing conduct. This reflects a collusive version of doxa or collective bad faith and requires wilful blindness from all of us in various degrees (we all lack ‘insight’ much of the time).

‘Wilful blindness’ is both a legal as well as a psychological concept. In law, it is a deliberate attempt to remain ignorant about facts relevant to a prosecution. In psychology, part of wilful blindness can be explained as a personal preference about what is familiar. What is familiar to us, is us (Heffernan, 2011). Applying this term in conclusion to our topic, wilful blindness has two relevant forms.

The first is in relation to those breaking ‘emotion rules’ seeking help voluntarily (Thoits, 1985). They can have their responsibility ‘medicalised away’ as mental illness to be treated. If it is familiar to us that problems in life are medical ones to be solved by medical treatment, then we are then permitted to adopt a passive patient role and avoid responsibility for our existential situation. We go to our GP and take the tablets given to us. This is why Szasz argues that ‘mental illness’ should be reframed as a form of game playing (not in the trivial sense), with a variety of parties winning or losing contingently in the transaction. At times the gain can primarily be for the identified patient: this is the emphasis on primary and secondary gain involved in adopting the sick role, which was emphasised by both Sigmund Freud and Talcott Parsons.

The second relevance, of the notion of ‘wilful blindness’ is that it illuminates ‘othering’. Unreasonable behaviour is more socially acceptable to us when enacted by people who we have some capacity to understand. This can be either the unreasonable behaviour of ‘normal’ people ‘like us’, or the unreasonable behaviour of people that can act as if they are ‘normal’ like us (the persuasive emollient politician or self-confident CEO). In other words, we will tolerate all kinds of unreasonable behaviours, such as the violence and harm that stems that from unrestrained weekend binge drinking, provided that it is from people who
are familiar to us. But we will not tolerate unreasonable behaviour from those unfamiliar to us. ‘Mental disorder’ can then be invoked to rationalise that discrepancy. When this occurs, the human rights violations of (some) mentally disordered people (such as imprisonment without trial and assaults on resistant bodies) are deemed to be completely acceptable to those who are normal by common consent. Thus, we cannot account for this occurrence by focusing on the mental health system alone – it has a ‘bottom up’ set of origins.

From an ethical point of view, this position is unsustainable. As Singer (1987) points out, ‘if we want to defend the principle of equal consideration of interests, we need to give equal weight in our moral deliberations to the like interests of all those affected by our actions’ (Singer, 1987). In other words, an interest is an interest, whoever’s interest it may be. For this reason, we should not respond to some people differently than others, if they are equally dangerous (whereas currently we do via the enactment of ‘mental health law’). Laws on dangerousness or suicide, where mental state is bracketed, would be non-discriminatory, whereas ‘mental health law’ is inherently discriminatory.

A more consistent and non-discriminatory approach is implied by all of the arguments above. We should be open about moral questions in relation to how, as a society, we wish to ensure compassion for those who are distressed, alongside reasonable expectations of culpability for all citizens. Compassion and culpability could be debated by all of us in order to go beyond our current contradictory legal arrangements. The latter manage to be both too punitive (by removing liberty without advocacy or trial for those committing no criminal act) and too ready to excuse (by removing responsibility for those outside of our moral order who are bad or mad by common agreement).

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**Author’s note**

This article is based on a paper presented at the *Disability or Distress?* symposium held at Lancaster University (15–16 November 2011). A (much) longer version is in press in *Disability & Society* (Pilgrim, D. & Tomasini, F. (2012). On being unreasonable in modern society: Are mental health problems special?)

**References**


In the February issue of CPF Richard Pemberton reviewed a recent book by Robert Whitaker called Anatomy of an Epidemic (Whitaker, 2010), and I want to develop the themes which the book examines from the perspective of a clinical psychologist viewing the issues from an ethical angle. The issue of medication might be seen by some as somebody else’s business (i.e. that of the psychiatrists). I have never looked at it like that, believing that I have been part of the services that have delivered these treatments and have witnessed the relatively quick improvements in patients when put on them, which have been one of the drivers for their use. Psychology can’t divorce itself from its role in the development of mental health services, and can indeed take credit for some successes – but it also needs to acknowledge if there are areas where we have wittingly or unwittingly contributed to harmful outcomes – and this may be one of them. I should emphasise that I am not criticising psychiatrists here, but considering the evidence which has accumulated concerning the likely problems associated with the way we have allowed our mental health services to become overly dependent on drug treatments that not only have side effects which are well known, but may also make recovery much less likely.

I first became interested in this issue in the early 1980s when I began my clinical career working in a psychiatric day hospital in London and many patients there had been on psychiatric medication for some years. I also worked as part of the programme which resettled patients from Cane Hill hospital, into Camberwell, and the residents there had been on these treatments for even longer periods. The emerging evidence was that the major tranquillisers produced brain changes that were substantial (Kerns et al., 1992). Patients developed all sorts of problems on the medication, and these were well documented, but it was all in the context of a widely held belief that there was little alternative. I was also aware of a literature suggesting that coming off medication, for example lithium, was associated with a return of symptoms, but more extreme than the original condition. It was not clear whether this was a progression of the disease (bipolar disorder) or a side effect of the medication. I wrote to psychiatrist colleagues at the time, and also asked about this, but it was not really considered to be a problem with the drugs, much more to do with the condition.

The other influence on my thinking in this area was when the ‘Whole Life’ programme (Department of Health, 2010) was taken on by the Trust in which I was working in 2004. This approach was derived from work undertaken by the World Health Organisation entitled The International Study of Schizophrenia (Sartorius et al., 1996), which looked at outcomes for people diagnosed using Maudsley criteria in different countries. One striking result was that people in countries...
with less well developed mental health services recovered much better than those in places like the UK and US. And the differences were not small. These results have been replicated (Hopper et al., 2007). I was and still am astounded by these results. There have been a variety of explanations offered, mainly concerning cultural differences, and these almost certainly play a part. But it always seemed to me that there was something else going on here and I think Whitaker makes a good case for the undeveloped countries doing better because they have not experienced the iatrogenic impact of the use of medication. An excellent overview of this work can be found in Richard Warner’s book, Recovery from Schizophrenia (Warner, 2003).

As well as the above a more recent consideration has come from reading The Rise and Fall of Modern Medicine (Le Fanu, 2011) which provides an excellent account of how the discoveries in medicine have not been from knowing the underlying cause of a particular disease, but much more by luck and screening lots of possible methods of treatment; and this is particularly true in psychiatry. All the talk, which you can still hear in the media and in some of the literature, about chemical imbalances being the cause of mental distress, has no evidence to support it.

Whitaker’s contention is that much of the medication used in psychiatry has short-term benefits but major iatrogenic consequences that have gone largely unacknowledged. The title of the book refers to the fact that mental health problems in the US (and a similar story can be told for the UK and other developed countries) have been rising exponentially, while other medical conditions have been declining. He draws on much research evidence to support the contention that it is the psychiatric medication that is responsible for this increase, which is underpinned by a relationship between the major drug companies and the psychiatric establishment inside which lurk major conflicts of interest. These conflicts of interest are well set out in a book by the ex-editor of the New England Journal of Medicine (Angell, 2004), who describes in forensic detail the way money has affected the research effort and led to scandals where the drug companies were fined extraordinary sums in punitive damages. A good website with an amusing name but with a serious purpose is NoFreeLunch, which provides information for medical students on the perils of big pharma and is well worth a look (www.nofreelunch.org).

And it is clear that things are not improving on the medication front. The NHS Information Centre (www.ic.nhs.uk) announced recently that 43.4 million prescriptions for antidepressants were dispensed in 2010–11. If, as Whitaker suggests, these are indeed possible causes of long-term problems, we are continuing to stoke up a major public health problem.

The ethics of all this reminds me in some ways of other situations where there are vested interests in one set of beliefs – for example, smoking and lung cancer, the way the tobacco industry reacted, and how confused people were about the evidence. So part of the ethical task of all interested parties here is to unconfuse ourselves; people with lived experience of mental health services, clinical psychologists and any other mental health professionals need to read what they can and try and understand if this is the case: Do the psychiatric drugs make you much more likely to have long term mental health problems or not? What are the relative risks and benefits of the different drugs for different conditions? Furthermore, if they do have these iatrogenic impacts, then there is an ethical responsibility to do something about it, including considering what alternatives we can offer.

Some British psychiatrists have pointed out many of these facts over past years – for example, Joanna Moncrieff. She wrote a telling account some years ago in a Maudsley discussion paper (Moncrieff, 2003) and also in her more recent book The Myth of the Chemical Cure (Moncrieff, 2008), and the review referred to at the outset of this paper also reviewed her more recent book Deomedicalising Misery (Moncrieff, Rapley & Dillon, 2011).

Most ethical codes would lead to the same conclusion. As an example, if you look at the Health Professions Council’s Standards of conduct, performance and ethics (Health Professions Council, 2004) it states in Section 1.
You must, at all times, act to protect the interests of patients, clients, users, carers and other members of the public. You must try to provide the best possible care, either alone or with other health and social-care professions. You must not do anything, or allow anything to be done, that you have good reason to believe will put the health or safety of a patient, client or user in danger. This includes both your own actions and those of others.

It is this phrase ‘allow anything to be done’ which is at the heart of the ethical response we need to consider.

If you do agree this is an ethical issue and requires some response you then have to consider what that might be, and that is not simple. In her Maudsley discussion paper, Moncrieff sets out some suggestions for her profession to deal with the conflicts of interest which flow from the way the pharmaceutical industry has operated. These centre around becoming completely open about psychiatrists dealings with the pharmaceutical industry, and the Royal College of Psychiatrists has published guidance in this area.

Probably, for us as a profession, the aim must be:

- To push forward on effective alternatives to medication.
- To ensure we are familiar with the literature in this area.
- To take seriously any reports of iatrogenic consequences of treatments whether psychological, psychiatric or medical (see Charles Vincent for some useful pointers: www1.imperial.ac.uk/medicine/people/c.vincent/publications).

Here are some suggestions of things that individuals might do:

1. If you work in a service where medication is being prescribed for psychological conditions, ask what is known about the long-term outcomes of any medication that is being prescribed as part of your team’s practice.
2. Discuss with public health colleagues, particularly mental health leads, whether they have reviewed this literature and encourage them to see it as part of their remit if they don’t.
3. Discuss in your faculty or branches whether this might be an area for debate and action.

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Ethics and the profession's relationship to diagnosis and psychiatric treatment

The profession's ethical obligation to challenge psychiatric diagnosis

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David Pilgrim & Steven Coles

The practice of psychiatric diagnosis is a dominant feature of many of the services in which clinical psychologists work. It is an everyday and unquestioned part of services. It is central to referrals, assessments, understanding people’s experiences (with service users, families, the public and media) and justifies actions taken to remedy people’s difficulties. It is integral to the design of services, receipt of financial benefits, and the foundation of the National Institute for Clinical Evidence guidelines on evidence based practice. It is ingrained in numerous administrative tasks, and communication between various services. Being deemed mentally disordered also may mean you have less legal protection for your civil liberties than the rest of society.

Despite the importance of diagnosis, British clinical psychology has not given an unequivocal statement on the practice. Doubts about it are expressed in the BPS document in 2000 on Advances in Understanding Mental Illness, but the Professional Affairs Board (1999) offers us this view:

Psychologists normally provide formulations based on psychological models and theories. In order to facilitate cross-referencing with other reports, a psychologist may use one of the Diagnostic classifications (i.e. Diagnostic and Statistical Manual-IV or International Classification of Diseases-10). For example, in some circumstances legal proceedings may be greatly assisted by a psychologist offering a diagnosis based on DSM-IV or ICD-10. (PAB, 1999)

Thus our guidance to date does privilege formulation, but it does not insist on a dismissal of the use of diagnostic categories.

Is it right for the profession not to have a voice on diagnosis? If psychiatric diagnosis were not a contentious area and a generally accepted practice, then there would be no reason for clinical psychology to have a position or to comment on the practice. However, psychiatric diagnosis has been criticised by numerous individual academics, a variety of professionals and people who have utilised services or have had them imposed.

Recently, the East Midlands Psychosis and Complex Mental Health Special Interest Group (SPIG) produced a position paper on psychiatric diagnosis (Coles & SPIG, 2010). This was offered in part to stimulate a debate about this lack of clarity from the profession. The paper highlights a number of problems with psychiatric diagnosis, including the lack of scientific legitimacy: it is simply not a reliable and valid way of understanding contextually embedded behaviour and experience.

Clinical psychology claims to offer coherent and robust psychological theories, to ground itself in research and evidence, and extols the virtues of the ‘scientist practitioner’. Is it right for clinical psychology, which claims to be a rigorous academic enterprise, to...
remain silent on the discrepancy between knowledge claims made by psychiatric diagnosis and its weak scientific legitimacy? Is it right for clinical psychology to use psychiatric diagnosis while being aware of this discrepancy?

The SPIG paper notes how psychiatric diagnosis privileges biology by basing the understanding of people’s experiences, behaviour and lives on a system designed to classify bodily dysfunction (medical diagnosis). Given the importance clinical psychology has given to unique individual formulations, which are multi-factorial and multi-levelled in their rationale, why has the profession not emphatically and consistently rejected the biological reductionism associated with the categorical reasoning of medicine? Why has the profession not commented on the discrepancy between the claims of diagnosticians that their practice is atheoretical in relation to putative causal mechanisms (‘aetiology’), while implicitly utilising a paradigm which presumes bio-determinism?

The position paper highlights that psychiatric diagnosis embeds a Western cultural worldview and imposes these assumptions on a diverse range of people, without any reflexive awareness about its epistemological colonialism. Furthermore, numerous accusations of discrimination (such as gender, sexuality and ethnicity) have been charged against psychiatric diagnosis (e.g. Shaw & Proctor, 2005). Whilst psychology has a less than illustrious history regarding equality and diversity, it seems unlikely clinical psychology would today want to condone discriminatory practice. If it is accepted that psychiatric diagnosis is discriminatory, is it enough for clinical psychology not to utilise diagnosis to avoid collusion? Should it go further and actively oppose diagnosis?

An argument is sometimes made that despite the numerous criticisms against diagnosis it should remain dominant as there are no alternatives. Is this good enough reason to continue the practice, if the negative effects of diagnosis are as significant as some critics claim? Furthermore, the East Midlands paper outline some modest ideas and principles for developing alternatives; and within adult mental health, the Hearing Voices Network advocates respecting a diversity of ways to understand people’s experiences, rather than the imposition of a single paradigm.

Psychological formulation is one possible alternative; a repetition of the question posed by Pilgrim (2000, p.302) highlights the contradiction that clinical psychology places itself in when it tacitly condones diagnosis: ‘Given that psychiatric diagnoses are at odds with context-specific formulations, why are they ever used by psychologists?’

If clinical psychology were to reject diagnosis as the dominant form of understanding within mental health services, there would still be ethical dilemmas to navigate. How do clinical psychologists work with services users who find some form of benefit in psychiatric diagnosis and perhaps have started to form an identity around this label? How could the profession ensure that it did not replace one form of exclusory expert knowledge with its own? In conclusion, it is surely time for clinical psychologists to break their routine silence about the questions posed above. Psychiatric diagnosis is at the heart of the medical domination of mental health services, if clinical psychology is to claim to be an autonomous profession with scientific integrity then complicity with diagnosis is surely ethically untenable.

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Exploring ethical standards

Boundaries of personal and professional ethics

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Tony Wainwright

This article considers the question of where the boundaries are drawn between professional and personal ethics. It also outlines some models for how the British Psychological Society (BPS) might extend its engagement with contemporary issues that challenge the way we live, and some of the ethical dilemmas this poses.

Declaration of interest
I am an academic clinical psychologist based at the University of Exeter. I am immediate past chair of the Society’s Ethics Committee and represent the Society at the European Federation of Professional Psychologists’ Associations (EFPA) Board of Prevention and Intervention, and am on the EFPA Human Rights Task Force. I am also a corresponding member of the EFPA Board of Ethics.

I have been a member of Friends of the Earth for some years, and while not currently very active, it is more from feeling a little disheartened about the chance of preventing dangerous climate change than disagreement with its aims.

This article represents my own views rather than being written on behalf of any of the organisations of which I am a member.

In this column I will raise some questions concerning where the boundary for ethics should be drawn for the profession of psychology (Pipes, Holstein, & Aguirre, 2005).

When I first started writing the Ethics Columns for CPF, one of my preoccupations was how to frame advocacy and campaigning in an ethical framework. At the time of my interview for the Chair of the Ethics Committee some years ago, I felt I wanted the Society to become more of a campaigning organisation, but this poses some significant problems for a learned society like the BPS.

I remain concerned about how we, as a profession, engage with the challenges that face us. To consider one aspect of this, I wrote an article called Climate Change and Refocusing Clinical Psychology (Wainwright, 2009), where I argued that the unprecedented nature of the impact of human activity on the physical environment meant we, as a profession, had a duty to take action. However, I also argued that conceptualising the relationship between the profession and these global issues was problematic. Traditionally, our focus has been on individuals and how we can assess them and then provide some help. But I don’t believe this is good enough. Applied psychology needs to raise its game. Climate change is not simply an academic question as the challenges facing us are so extreme and urgent. As I wrote in the earlier paper (Wainwright, 2009):

I do not think it is an exaggeration to say that climate change poses a major challenge to human civilisation. The impending transformation of the physical environment is unprecedented in human history. Alongside these changes are the equally unprecedented losses of animal and plant species through habitat destruction. Furthermore, the human population has grown at an exponential rate over the last two centuries – both a success story as infant mortality has dropped and people are living longer, but this also presents further enormous challenges to global resources. (Wainwright, 2009, p.7)

For the purposes of this discussion, the BPS is the body that represents psychologists in the UK and stands as a proxy for the collective
ethical position of psychologists. Whilst there may be a diversity of opinion within the profession, I believe that on some issues there may be a moral imperative to take a stand and it would be possible to proceed using the usual democratic mechanisms.

The Society is governed by the Royal Charter, which requires the publication of a *Code of Ethics and Conduct* and *Member Conduct Rules*. These provide the waters in which the profession currently swims. The framework for the Royal Charter was laid down nearly 50 years ago when the world was a very different place and we may have reached a time when we need to review it.

A subsidiary question I will address is whether our *Code of Ethics* is drawn too narrowly. At present, its principles are four in number: integrity, responsibility, competence and respect. It is possible we could derive some broader action from two of these in particular (responsibility and competence), and I will come back to that later.

While my interest has been in climate change and related environmental issues, the tensions involved in developing a more active engagement with topics of public concern can be illustrated by taking us back to 1987 and the issue of apartheid and the response of the Society. In the January 1987 issue of the *BPS Bulletin*, which was the Society’s house journal, 96 signatories wrote a letter asking for the Society to clarify its position on the links between psychologists in Britain and those in South Africa. This had followed from the Annual Conference of the Social Psychology Section, which decided to promote some public debate on the issue. In the letter they noted that The Royal College of Psychiatrists had voted to break off links with South Africa and while there was considerable debate, this was seen as within the purview of the Royal College (*Psychiatric Bulletin*, 1988, 12, 142–143).

Another letter to the Society followed (Baron-Cohen et al., 1987), signed by, amongst others, some significant figures in contemporary psychology – Simon Baron-Cohen, Philipa Garety, Liz Kuipers and Til Wykes, reinforcing the call for a strong stand against apartheid. Karen Henwood (Henwood, 1994) summarises the heated and difficult debate which followed and which finally resulted in the following statement:

*The Code of Conduct of the British Psychological Society requires psychologists ‘Not to allow their standards of professional responsibilities or standards of practice to be diminished by considerations of religion, sex, race, age, nationality, party politics, social standing, class or other extraneous factors. The racism of apartheid is incompatible with the Society's Code, and the Society therefore condemns apartheid and resolves to avoid all links with psychologists and psychological organisations and their formal representatives that do not affirm and adhere to the principles in this clause of its Code of Conduct.’* (Henwood, 1994, p.48)

Firstly, as at least to some degree the resolution of this debate rested on the Society’s *Code of Ethics and Conduct*, it is here that we might consider whether the Code itself could be widened in scope. The Society has endorsed the *Universal Declaration of Ethical Principles for Psychologists* (International Union of Psychological Science, 2008), which includes Principle II: ‘Competent caring for the well-being of persons and peoples’, and Principle IV: ‘Professional and scientific responsibilities to society’. The duty to care for peoples (as distinct from individuals) and the responsibility to society, give the Universal Declaration a political (with a small ‘p’) edge. Can an organisation sign up to this declaration, without recognising that there are peoples being affected by climate change, poverty and other global challenges?

A second point concerns our responsibility as scientists to contemporary science. When the Royal Society and the US National Academy of Science jointly produce a document setting out the scientific case concerning anthropogenic climate change (Cicerone & Nurse, 2014) and which demonstrates that human activity is the critical factor leading to the changes being observed, we need to take notice. Elizabeth Kolbert’s recent book (Kolbert, 2014), I am sure would convince you that
biodiversity loss is happening at a breakneck pace, also as a consequence of human action. As applied psychologists we are part of the scientific community that has identified these processes.

It is possible that our response to these issues is limited by there being no Division or Section on environmental psychology. There is a substantial opportunity for the Society to have a leading voice in this field as psychologists are already carrying out much exciting and innovative research. At Exeter University, for example, we have a thriving department of Human Geography where Professor Patrick Devine Wright carries out his work. They run an online course on Climate Change, which includes the way people respond to wind turbines in their neighbourhood – the so-called NIMBY (Not In My Back Yard) phenomenon where local people are defined in quite negative ways (Devine-Wright, 2013). He applies psychology to this important area and makes a compelling case for understanding these responses as being to do with ‘attachment to place’, a positive human attribute, and how this can provide a very different framework for public policy.

We can learn from other psychology societies that have taken a broader approach. The Australian Psychological Society (APS) lists 13 key areas for its work under the rubric of ‘Psychology in the Public Interest’ – a clear nod in the direction of an ethical duty, including human rights, indigenous Australians, LGBTI issues, psychology and the environment, racism, refugees and asylum seekers, sexualisation of girls, torture, and violence and social justice.

They say that: ‘The role of the APS Public Interest Team is to take a proactive approach to issues where psychology can make a contribution to public debate and policy in the interests of community well-being and social justice. We are developing materials (position statements, submissions, tip sheets, media releases, etc.) in a range of areas to assist the APS to speak authoritatively on matters of public concern, in ways that can be readily understood by decision-makers, the media, and the general public.’

Perhaps it is the history of the difficult debate on the South African question, and what was and was not ultra vires that could make us cautious about tackling some contentious areas of public concern, and one solution might involve widening the scope of our Code of Ethics and Conduct to take into account communities; ‘peoples’ in the Universal Declaration terms. This might open up areas that we could tackle, and while not exactly ‘campaigning’, might come closer to allowing us to take a stronger position on some of these challenging questions. The link with the two principles: (i) competence (we need to be sure we are on solid scientific and ethical grounds when we speak as a profession); and (ii) responsibility (responsibility to peoples and to also subsequent generations) would then provide a framework for us to promote the public voice of psychology. Tommy Mackay expressed some of this beautifully over ten years ago in his presidential address to the centenary conference in Glasgow (Mackay, 2001):

> It is time for psychology to rise up and assert itself in its central role in all human affairs and progress. I believe psychology has a key part to play in getting crime out of our cities, litter off our streets, illiteracy out of our schools and inequity out of our society. It is time to stand up and, as a great discipline, make a bold declaration: The future belongs to psychology. (Mackay, 2001, p.469)

I will finish by recommending you read an ‘op-ed’ piece by Michael Mann (Mann, 2014), long time climate scientist, who has become politically active as a result of personal attacks because of his scientific work, finishes his article by saying:

> How will history judge us if we watch the threat unfold before our eyes, but fail to communicate the urgency of acting to avert potential disaster? How would I explain to the future children of my eight-year-old daughter that their grandfather saw the threat, but didn’t speak up in time? Those are the stakes.

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WHENEVER we see someone behave in a certain manner, unless there is an obvious reason to doubt it, we make an assumption that the person is responsible for their actions. In many cases, using the idea of responsibility does not appear problematic; for example, if someone parked their car so that it blocked the entrance to an emergency hospital whilst they went to the corner shop, most people would probably quickly agree that this action was irresponsible. However, there are complexities and potential difficulties with using the notion of responsibility. How useful is the concept of responsibility? Is it necessary? Is it helpful? What are its limits? We feel such reflection is necessary as Western cultures tend to place a great deal of emphasis on the individual. Western societies are less concerned with the web of influences upon the individual; therefore, when we think of responsibility, we tend to think of individual responsibility.

The use of responsibility in clinical work: Examples from mental health
Moral and ethical judgements about people’s behaviour are at the heart of the field of mental health. One of the reasons people receive a psychiatric diagnosis is because their behaviour has been judged to be different from what is currently expected in a particular society (Coulter, 1973, 1979; Rogers & Pilgrim, 2010). For example, a person who is not performing their usual roles, responsibilities and activities, and is not reciprocating in relationships will often receive a diagnosis of depression. Or a person might be given a diagnosis of schizophrenia, if what they say and do is interpreted as not making sense, particularly if the person is unable to give a culturally acceptable explanation for their behaviour.

When someone is labelled with a psychiatric diagnosis we often limit our judgement of how responsible someone is for their actions. There are perhaps some gains in having some of these responsibilities and expectations removed. For example, it has been argued that for someone experiencing low mood and lacking in energy (‘depression’), being temporarily placed in the ‘sick role’ can take away some of the pressure of social expectations, validate their need for help and creates space for recovery (Weissman, Markowitz & Klerman, 2000; see also Parsons, 1951). What about costs? For many this sick role can become a more permanent state of being; therefore can be damaging to someone’s identity, lead to negative judgements from others and place the person in a devalued position in society. Furthermore, removal of responsibility in the form of the sick role implies an illness/biological cause to a person’s distress rather than one grounded in life experiences, and therefore minimise the social, ethical and personal dilemmas involved. Also, the judgement of lacking responsibility due to the application of a psychiatric diagnosis has serious consequences for a person’s civil liberties and freedoms. The result is often a greater risk of
coercion, and less safeguards than are experienced by the general population (Vassilev & Pilgrim, 2007).

How responsibility is judged in mental health services is complex and varies according to diagnosis. Within clinical work, judgements are often made as to whether something is ‘illness’ or ‘behaviour’. An example would be the difference between someone who describes hearing voices, who acts on them and smashes a window versus someone who struggles with rejection smashing a window after a staff member does not arrive for an appointment. In the first instance staff are likely to see the person as not being entirely responsible for their actions, whereas in the latter, workers would probably see the person as being in control and individually responsible. Is this a fair judgement of responsibility? In their own ways, both people were responding to internal experiences that were not of their own choosing: the first a voice, the second a feeling of rejection. So why do we make differing judgements as to their responsibility for smashing a window? The judgement of being responsible or not is important as it can lead to different forms of care and empathy being experienced.

But what underlies our judgements of responsibility? Our understanding of the immediate context of the behaviour has a large influence on the judgements we make. In the example above, the presence of voices can lead us to view a person as having less control of their actions. In the absence of anything obvious in the immediate context, the common conclusion is often that the person could, and should, have acted in a different way. This may lead to statements such as ‘the person just needs to take responsibility for their actions’. What does this statement mean in practical reality? Are such statements neglecting the complexity of why people act the way they do? Even if we accept someone does need to take more responsibility, how are they going to achieve this? What is the responsibility of services in helping the person accomplish this?

**Why is the concept of responsibility limited?**

What is often missing from our analysis of behaviour is a wider perspective on what influences how we act and the reasons for doing so. Within the modern era we have come to highlight concepts such as personal autonomy, responsibility, and our ability to think through situations and act based on our cognitive appraisal. Yet we need to remember that our bodies and brains have developed over millions of years to survive and reproduce, not to think through situations logically. Such instincts and brain structures have not been replaced, but have been added to by the higher functions of language and conscious thought (Gilbert, 1992). Furthermore, our brains develop based upon our experiences of life (see for example Read, Fosse, Moskowitz & Perry, 2014), and our feelings and subsequent ability to act in the world are shaped by the society and culture we live in (Cromby, 2007; Cromby & Harper, 2013).

A further difficulty with using the concept of responsibility in relation to behaviour is the fact that we have very limited awareness of why we do things (Moloney & Kelly, 2004). Much of what drives our behaviour is outside our conscious awareness; and even if it isn’t, the sheer enormity of possible influences can severely restrict what we choose to do at any point in time. For example, many of us regularly try to eat more healthily and exercise more. Yet cast your mind back to the last time you supposedly could have done more exercise, or eaten more healthily but didn’t. Why not? In such situations we may well just react rather than act based on a logical analysis. Furthermore, instant reactions are more likely when we are frightened, isolated or highly distressed. Indeed, such feelings may well activate responses which are fundamental to our survival instinct.

**Power**

Rather than just apply the concept of responsibility with its somewhat binary out-
come of yes/no, we would argue for a more sophisticated analysis of behaviour based on the power that a person has to act in different ways, in any given situation (Smail, 2001). Power interacts with factors such as material resources (e.g. money, work, education, housing), home and family life (e.g. love life, partner, siblings), social life (e.g. friends, leisure, associations), and personal resources (e.g. our appearance, intelligence, confidence) (Hagan & Smail, 1997). We simply do not have unlimited options available to us, and the likely occurrence of any given option is based on our current level of power and influence.

An analysis of power can be applied to behaviour seen within clinical practice. Examining how much power a person has (or does not have) to act in various ways gives us a more sophisticated analysis that is ultimately more compassionate. Rather than simply placing responsibility on the person to change (or on ourselves to change them), we can try and understand some of the forces that make change difficult, not just for our clients, but for all of us. On occasions someone might have the power to act in a certain way and choose not to; however, we often vastly inflate a person’s ability to choose to act. Sometimes we, or the person themselves, may not be able to enhance their level of power sufficiently to broaden the behavioural choices available to them. Rather than blaming ourselves or them for lack of progress, we can try to understand their behaviour within the constrained human bodies and worlds we all inhabit.

**Final comments**

Perhaps the idea of responsibility is at times culturally necessary and pro-social, if it means we think about our responsibilities towards each other and the responsibility of people, groups and organisations in positions of power towards those with limited means of influence. What we need to be mindful of though, is the fact that when we use the idea of responsibility we are using a moral rather than a clinical concept (though this is the case for much of mental health work). The idea of responsibility is problematic, particularly when applied to those with limited power and resources. In these circumstances we need to consider pragmatically what the most useful course of action is. We must also be aware of our own limitations so that we can best support a person’s development.

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The findings of the report on poor care at Stafford Hospital have set many ethical hairs running. One important one was the plea from some campaigners to demand that the norm in the NHS should be to do no harm. In its most ideal form, this would treat a hospital or a healthcare intervention like an aeroplane: constant checking on safety and immediate removal of risk. If in doubt, keep the plane on the ground. And this expectation about the principle of non-maleficence is common in medical ethics but it is not without its problems, when considering competing principles or when using it as an analytical starting point, if we are faced with untoward events in healthcare.

The historical origins of the ‘do no harm’ stricture are contested (Gillon, 1997). The Latin injunction ‘primus non nocere’ may have started with Hippocrates in his *Epidemics*, but it is not actually in the original Hippocratic Oath, which says more vaguely ‘abstain from whatever is deleterious and mischievous’. It is likely that it is in the translation of the *Epidemics* by Galen that the words ‘above all do no harm’ appeared.

But if we now all hope that those charged to help us will keep in the front of their minds the priority that they will do us no harm, then how tenable is this? Also, does doing no harm mean ‘if in doubt, let things be or leave good alone’? This orientation makes intuitive sense. However, by definition those exposed to the risks of harm from healers and healthcare systems are there for the very reason that, according to them or others, they are not in a good state to be left alone. If we let things be and do without the clinical interventions that are suggested by others, honestly but paternalistically, or demanded by ourselves anxiously, then we are exposing ourselves to the risks of non-intervention. The latter is considered a particular risk in relation to a number of conditions from early diagnosis of cancer to the prescription of drugs for ‘clinically silent conditions’. For example, should we accept the lowering of diagnostic thresholds to trigger the receipt of low doses of anti-hypertensive drugs or statins?

And then the ultimate dilemma of interventions for the patient-yet-to-be relates to childhood immunisation. The risks to an individual child of harm from the latter are tiny but not completely absent. And when a particular child does suffer anaphylactic shock or an abnormal reaction, which might cause them long term harm, then the risk to them has proved to be 100 per cent. Moreover, in this case the choice around harm implicates a target that gives no consent and a harm reduction strategy that requires collective compliance (to create ‘herd immunity’). Thus the ethical driver is as much about population level prevention as it is individual risk of disease. For example, a male child contracting rubella risks no individual harm and for that matter neither does a pre-pubescent girl. A mother of a well-nourished child may err on the side of caution and be ‘non-compliant’, but in conditions of poor nutrition in parts of Africa vaccination is recurrently and undoubtedly life-saving. I come on to context...
being all important below, but here I simply note that anxious mothers in Britain and Africa have differing but equally understandable situated rationalities.

The overall point I am making here though is that medicine could barely function, if the ‘do no harm’ injunction was privileged above all other practitioner motives. What the understandable rush to expect a ‘no harm’ priority in healthcare, when poor care is exposed highlights is that life is risky. If we have a professional enterprise called ‘healthcare’ then like all enterprises it will have costs, not just benefits. Drugs properly prescribed still have adverse effects. Cancer treatments used in good faith to increase survival rates are debilitating. Psychological therapies can lead to ‘deterioration effects’. What the Stafford Hospital debate has confounded at times are necessary but imperfect risk calculations or option appraisals about good practice with the matter of negligence. Non-negligent healthcare practices can still do harm.

These tricky dilemmas revolve around what iconoclastic critics of medicine have called multi-facetediatrogenesis. Illich (1974) warned of three forms. First, and the most obvious, is clinicaliatrogenesis: the wrong leg sawn off, the occasional life risking drug reaction, the hospital acquired infection or the patient abused by a psychotherapist. Second, we have culturaliatrogenesis, which is about the erosion of non-medical positive personal adaptations to variations in our health across the lifespan from a wide range of professional and commercial sources. Third, socialiatrogenesis compounds that weakening of non-medical adaptations by extending medical expertise to more and more physical and psychological variations in life.

If the first of these is a risky arena, inviting more managerial controls from within our ubiquitous ‘audit society’ (Power, 1998), the second two are about the health professions imperialising more and more of our lives under the encouragement, though not always the initial instigation, of the drug companies and other profiteers in healthcare. In the case of psychological interventions, expanded professional jurisdiction is the main driver. For example, in the case of psychoanalysis we are all considered ill and so prospectively we could all benefit from regular personal feedback. (Given that so many of us are tired of living and scared of dying, psychoanalysis or other forms of psychological therapy for all would of course be more expensive than putting anti-depressants in the water supply.) We also find such a colonisation of the suffering self in the rush to offer ‘counselling’ whenever life goes distressingly wrong for anybody, which it does for us all sometimes and for some of us more than others during our lives.

Sociologists gather these processes together under the umbrella term ‘medicalisation’ (Conrad, 2007), and collectively they imply two socio-ethical concerns. The first is that sickness and death can be avoided, when they cannot. The second is that it might be worse to hand over our vulnerable complicated selves to healers than to struggle with our vulnerabilities on our own.

Above, I have presented some generic provocations about healing and healthcare, but they are all just academic exercises until we contextualise them on a case-by-case basis. A good starting point about the importance of context and the fluidity of vulnerability in our lives, unto death, is the following observation from Susan Sontag:

*Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, is to identify ourselves as citizens of that other place.* (Sontag, 1978)

This is a good starting point but ‘the spell’ that she talks about occurs more often and for more time for some of us than others. For example, it happens more as we get older. At all parts of the lifespan the poor are less healthy than the rich. Moreover, where this happens in part determines how risky is ‘that other place’. In the case of the Stafford scandal this was about a range of people, from those who were acutely injured and died untreated (e.g. the young man with the undiagnosed ruptured spleen) to elderly patients...
with multiple morbidity, dehydrated and left in dirty linen. In each of these circumstances, the injunction to ‘do no harm’ required different benign rather than malign responses.

In the first case, a highly medicalised setting (an A&E department) was the right one but the clinicians technically failed in their duty of care, with fatal consequences. In the second, maybe hospitals simply are the wrong place for end of life care. Why would we expect complex techno-centric medicine to attend to our personal needs, when medical knowledge has lost its curative potential during terminal care and its practitioners might easily have lost their interest or way? Hospices had to emerge for the very reason that acute hospitals, even ‘non-scandal’ ones, are not routinely good at holistic care. What the best acute hospitals can and should do is apply appropriate medical knowledge in order to maximise the chances of cure and minimise clinical iatrogenic risk. At Stafford and some other hospitals (as it is now emerging) that medical knowledge seemingly went absent without leave too often.

For example, hospital acquired infections are minimised in some hospitals, yet go unchecked in others, leading to wide variations in incidence, within and across national jurisdictions. This suggests that ‘doing no harm’ should be a systemic not individual matter. Indeed, one weakness of an ethical frame of reference is that it tends to be limited to the latter and blind to the former and encourages psychological reductionism about poor care in relation to practitioner conduct alone. If, say, the Netherlands has had 40 times less hospital acquired infection than the UK, then we have to look at hygiene routines or norms and environmental design as the main reasons. Moreover, given that the vulnerability to infection frequently implicates the underlying medical condition of those who become infected (because of their compromised immune system), hospitals are not necessarily always the best place to be when we are ill.

Part of cultural iatrogenesis is our belief that hospitals are benign and helpful places, when this is a highly contestable assumption.

When J.P. Martin analysed the features of ‘scandal hospitals’, he noted that moralistic bad apple theories are reductionist and we have to develop a systemic view of complexity in healthcare, if we are to avoid what he called ‘the corruption of care’ (Martin, 1985). He also noted that aspects of poor practice varied widely from the honest mistake to deliberate malign conduct. Abuse and neglect are continua and are linked to a range of motives from well-intentioned muddle-headedness and incompetence to sadism, or from mistaken oversights to wilful blindness... and all stops in between.

Martin’s guidance about systemic complexity remains relevant to the Stafford Hospital report. In its wake, a range of journalistic commentary, radio phone-ins and letter writers have offered us single factor reductions: immoral staff; brutal book-balancing managers; understaffing because of resource constraints; the loss of an ethos of care in nurse socialisation and practice; poorly paid foreign care assistants; creeping privatisation, etc. These factors are all relevant to investigate but any one of them alone cannot account for why there was a ‘corruption of care’. Searching for the reason behind poor care in single factors is like looking for ‘the cure for’ or ‘the cause of’ cancer, which is actually a set of complex conditions, with multiple generative mechanisms.

In this light, simple prescriptions like ‘do no harm’ need converting into careful fine grain and contextualised psychological formulations, if good practice is to be encouraged. Simply to know that one should not do harm is not a very good predictor of whether harm will be done. For example, we know that in our field, therapist abuse is often perpetrated by senior and highly trained practitioners. Equally, completely untrained people might act benignly at all times. We need to make sense of that contradiction in practice and case by case.

Finally, the expectation that healthcare system can ever be risk free is ridiculously
unrealistic (Pilgrim et al., 2010). For example, hospital acquired infections can be reduced dramatically but they can never be eliminated. Similarly, medical accidents and deliberate malpractice will always occur; that is why a whole bureaucracy exists to anticipate and deal with litigation for the NHS (the NHS Litigation Authority). Accordingly, all healthcare systems must have a constant financial reserve for compensation payments to be made in relation to iatrogenic disability or death.

Tactically, those campaigning for a policy of ‘above all do no harm’ are possibly correct to aim high. This demand is utopian and can be at odds at times with other imperatives. But, culturally, it might be the only way to maximise our achievements in the future. Best practice might have to come from unrealistic expectations; the goal will never be achieved but the game will be lifted. Nonetheless, risk minimisation is a complex matter and solutions lie more in systemic sophistication than in moral injunctions to individual practitioners alone. The role that individual ethics plays in that systemic cleverness is not irrelevant but it is clearly not the whole picture. This is why questions of hospital design, collective routines or norms, staffing levels and drug company profits all must be part of our analysis. What individual practitioners more modestly can do though is first exercise a duty of care in good faith, as often as possible, and second, be candid when they observe errors and poor practice in their midst. Unfortunately, at Stafford too many staff did neither.

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I AM VERY PLEASED to introduce myself as the new DCP ethics representative and I will be acting as a link to the Society’s Ethics Committee. I feel ethical reflection, debate and questioning are fundamental to the work of clinical psychologists, and so I am keen to continue this column and the work of Tony Wainwright and David Pilgrim as one format for promoting and encouraging these important discussions. My own background is in adult mental health, but I am eager to encourage discussion across all areas and many issues are likely to resonate across specialities. To my mind, a fundamental of ethics is the sharing of a diversity of opinions, discussion and disagreement, as well as understanding.

I recently realised certain questions have been seeping into my conversations and my writing: What do I professionally stand for? What are the core values of my profession? What should they be? In essence as a psychologist I have been pondering Sandel’s (2010) reflective question: What’s the right thing to do? Whilst for some this might feel unhelpful navel gazing as a substitute for action, I feel clinical psychology could usefully spend more time on such questions to better inform and encourage what we say and do. I believe the profession has emphasised the scientific component of the profession in how it presents itself to the world and has overlooked the ethical and value based dimensions. I hope this column can help the profession reflect upon, debate and flesh out what we stand for and value.

A value which feels self-evidently important is honesty, and its close relation transparency. I doubt there are many who would question these values as reasonable; however, beyond simply repeating these words, what does honesty and transparency mean in practice? The Division’s Core Purpose and Philosophy of the Profession (DCP, 2010) mentions honesty as part of a core value of integrity, but gives few details as to what this might look like. Interestingly, the vast majority of the document is focused on purpose rather than philosophy, and more on science and research than ethics and values. The Society’s Code of Ethics and Conduct (2009) provides additional details of what constitutes integrity. The following quotes caught my attention:

...be honest and accurate in conveying professional conclusions, opinions and research findings, and in acknowledging the potential limitations...

and:

...be honest and accurate in advertising their professional services and products, in order to avoid encouraging unrealistic expectations or otherwise misleading the public.

Are these values a challenge to what we do and say in day-to-day practice? To test this I wish to consider the example of individual therapy.

Clinical psychology retains a wide remit and range of roles; however, it has placed a great deal of emphasis on individual therapeutic work, particularly through IAPT and cognitive behavioural therapy (CBT). The
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Acronym CBT can often be found on the lips of popular radio presenters when discussing mental health, and service users often request this therapeutic modality due to media exposure. This has led to much philosophical and empirical debate about the value of CBT and individual therapy, with avid promoters and staunch detractors. The former often make strong empirical claims for CBT, while the latter argues CBT is unhelpful as it hides the real problems people face. Many point to research which indicates that even if therapy is helpful then the relationship, rather than technique, appear key (e.g. Hubble, Duncan & Miller, 2005). Even cognitive behavioural therapists have questioned the usefulness of thought challenging (Longmore & Worrell, 2007). I want to sidestep the rather complex empirical question of whether individual therapy and CBT works and instead ask: Do the values of honesty and transparency require us to share this debate with service users?

Shared with the public? If so, how should it be done, when, in what format and to what extent? Is this transparency common in individual work? What are the advantages and disadvantages of doing this?

In an attempt to be transparent regarding my own perspective, part of my role is working with people individually, though I am on record as questioning the expert driven approach to individual work.

Therapy is not the only area that is highly contested in psychology and this will always be the case as clinical psychology focuses on, and is part of, complex open systems in which we often try to make sense of experience. Easy truths are hard to come by. To my mind it is vital that we are transparent about the status of what we know and we are open and honest about the contested nature of ‘truth claims’. I believe this requires us to try to adopt a certain measure of modesty as to what we know. Whilst modesty does not feature explicitly in the Society’s ethical code, it is implied in the avoidance of unrealistic expectations and being open about potential limitations of professional opinions noted above. However, such a perspective is hard because formation of a profession is partially based on claims to specialist and expert knowledge and technique. Perhaps the value of modesty is in keeping in check exorbitant claims to expertise, and therefore supports honesty.

Honesty and transparency are crucial and core values for the professions. Whilst easy to say and sign up to, the example of individual therapy highlights that honesty and transparency are perhaps far harder to fully enact when doing so is not felt to be in our professional interests. Perhaps the most honest, important and hardest phrase for a professional to utter is ‘I don’t know’.

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IN MY PERSONAL LIFE and my professional career I have been oriented to experience, context and personal history. This has meant I have been open to what is classed as trauma and its importance. However, I have realised that I have at times looked away from the full horror of people’s experiences and stories. Within individual work this does not mean that focusing other aspects of someone’s life always constitutes avoidance. I believe there are legitimate times that the right course of action is not to focus on the past, such as a service user’s wishes and the importance of a client’s current circumstances taking precedence. We also need to remember to view people as a whole and not simply as a victim: their strengths, multifaceted identities and dreams. However, we also shy away from ‘facing the unspeakable’ (Herman, 1997, p.4) for less rationale and justifiable reasons.

Clinical psychology as a profession has perhaps been better than others in addressing trauma; however, I do not believe the profession has fully appreciated its duty to social justice in light of our knowledge of widespread abuse and misuse of power in society. Our witnessing of the consequences of abuse sets us a significant moral challenge that goes beyond therapy. I would suggest the principle of beneficence urges us to go further than attempts at amelioration of harm through therapy. I believe the principle requires us to speak up in public about misuse and abuse of power in an endeavour to contribute to finding ways to prevent and minimise such occurrences. As a matter of transparency, and given a theme of this article is about the ethical obligations and potential direction of clinical psychology, it should be noted that I recently became a member of the DCP Executive; however, the views expressed in this article are my own.

What is the horror?
Abuse takes many forms: domestic violence, neglect, bullying, racism, neglect, and so forth. Some experiences and events are patently damaging; for other people the circumstances are more complex and subtle, but often equally troubling. The flow of power is usually crucial in each. The data around the numbers of people experiencing some form of abuse varies; however, the trend is clear – it is extensive and harmful. For example, if we consider sexual violence, figures indicate that in the general population nearly 20 per cent of women and 5–10 per cent of men have experienced child sexual abuse (Longden, 2012; Pereda, Guiller, Forns & Gomez-Benito, 2009). The British Crime Survey estimated that three quarters of a million women had been raped since the age of 16 (Myhill & Allen, 2002). A recent study in the Lancet indicates that 9.8 per cent women and 1.4 per cent of men in Britain had been forced into sex against their will since the age of 13 (Macdowall et
Unsurprisingly, such experiences have emotional and social consequences (e.g. Tyler, 2002; Varese et al. 2012). Whilst the data tells part of the story, personal testimony adds depth and emotional resonance:

*I inhabited a dual world. In one, I was a normal schoolgirl with normal parents... In the other world, I was a dirty little bitch, evil and unlovable, treated with cruelty and contempt.* Dillon (2011, p.141)

*I believe my experiences of paranoia relate to sexual abuse from when I was five and up to the age of 13... Quite often she would hang me from the banister by a silk scarf, and would only let me down when my eyes rolled.* Bullimore (2010, p.12)

To stand as witness to the extent and horror of such trauma is to encounter and experience feelings of fear, despair, loss and rage. It is deeply troubling to live in a world where power is so badly misused. I believe the intense emotions related to the awareness of such abuse is one of the reasons it slips out of practitioners’ and society’s consciousness. It is simply too terrible to stand. Obviously we cannot be continually experiencing such pain. However, we should not avoid it completely; we need to be able to experience these emotions, so to bear witness and stand beside those who have survived. Feelings such as anger, if channelled, can also perhaps help motivate us to speak up against abuses of power.

**Sanitising and hiding the horror**

I believe clinical psychology and other professionals have the potential to help bring trauma and its impact into the wider social consciousness, with some practitioners already doing so (e.g. Johnstone, 2007). Mental health professionals have also done considerable harm in concealing and individualising abuses of power. For example, let us consider how we classify emotional and relationship problems in which a majority of people have experienced great trauma – sexual abuse, extreme life events and repeated abuses of power – we created and apply the label ‘borderline personality disorder’. For people who have experienced some of the worst society can imagine, rather than being amazed at someone’s survival against the odds, we have labelled the core of their being as disordered. This act of labelling and medicalisation sanitises the horror of the acts of abuse – understandable emotional consequences of rape and valiant attempts at survival become symptoms of disorder. In essence, the diagnosis strips people’s experiences of their meaning and emotional resonance. The word ‘trauma’ can also be seen as sanitising the horrifying experiences people have had, as we do not need to articulate the horrendous nature of what has been experienced. It allows us to put distance between ourselves and the pain (see Boyle, 2006; Johnstone, 2011). Minimising the horror weakens our resolve to act on the principle of beneficence.

The diagnosis of borderline personality disorder locates the problem within the individual. ‘BPD’ hides disordered environments, misuses of power and perpetrators of abuse. Standard undergraduate textbooks and psychiatric texts, with notable exceptions (see Cromby, Harper & Reavey, 2013) give limited space to environmental theories, instead relaying standard reductionist biogenetic theories (Harper, Cromby, Reavey, Cooke & Anderson, 2007). As an example, a chapter on borderline personality disorders in a recent mainstream textbook highlights genetics, neurotransmitters and neurocognitive factors. Whilst it does discuss childhood adversity, the rhetoric of the chapter, despite providing no substantive evidence, attempts to suggest such adversity and maltreatment may well have genetic roots, such as a child’s ‘difficult temperament’ (Hooley, Cole & Gironde, 2012, p.420).

In contrast, the knowledge of lived experience often tells a different story; for example, Suzi someone who received the label states:

*I cannot understand how the vast majority of perpetrators of sexual violence walk free in society; whilst people who struggle to survive its after effects are told they have disordered personalities.* (In Shaw & Proctor, 2004, p.12)
In general I would argue the label of BPD is not only a sign of professional failure to recognize the widespread abuse of power in society and its impact on people, it is an example of the concealment of such power. Boyle (2011) has argued that clinical psychology and psychiatry are threatened by fully embracing social context, as doing so brings into sharp focus political issues, such as the subordination of women and children. Addressing such issues would put the profession at odds with powerful groups in society. Social context also undermines the importance of individually focused interventions – if the root causes of distress are located in the environment, then at best therapy is only a limited solution. It is anxiety provoking to fully embrace trauma, not only at a personal level but as a profession.

Facing the moral challenge
Clinical psychology faces a dilemma. It has awareness and knowledge of trauma, its social origins and emotional impact, but embracing the implications of this awareness, taking a stance and speaking up in public could upset other powerful groups. In weighing up our duties to act beneficently, I believe the extent and magnitudes of the horrors we witness outweighs the potential risk to professional interest. However, anxiety may prevent clinical psychology acting on this principle and it may choose to avert its gaze or keep its voice contained to the therapy room. For the profession to do what I believe is the right thing, we would need to start asking ourselves questions such as:

- How have we contributed to the concealment of abuse and misuse of power in society? What do we need to stop doing if we are to be part of the solution rather than part of the problem?
- How can we monitor and minimise professional interest in distorting how we address abuse and violence in society? Can we maintain a level of modesty? Can we fairly appraise our limits as well as appreciate what we can legitimately offer? Can we be open about the limits of therapy?
- What are we doing that is helpful and can be built upon? Do we need to have trauma informed services, rather than mental health services? How do we need to evolve clinical training courses, so they are more attuned to issues of trauma and power?
- In the public realm, do we have something helpful to say about the misuse of power in society? Can we speak about abuse without offering a simple or individualistic solution? How do we share our ideas with the public? What is the role of social media?
- What can we do to stand beside people who have survived the misuse of power? How do we ensure we do not dominate or silence their voice?
- What groups can we make alliances with and support? Who are the experts on abuse and misuse of power outside of psychology?
- Can we start to work more with communities rather than individuals? Is a public health agenda a possible future for clinical psychology?
- How can we promote a world which decreases the risk of people doing horrendous things to each other in the first place? Can we help develop communities which nurture human growth? Are there risks to others from our involvement?

What sort of economic, employment, education and childcare policies contribute to the well-being of society and decrease oppression? The answers to such questions will be complex, and I’m sure there are other ones that need to be asked; however, I do believe these are the sorts of questions we need to reflect upon to develop as a profession. I am also hopeful that we have started, tentatively and in certain areas, to have clarity on what we stand for and to voice it in public. For example, the DCP (2013) position statement on functional diagnoses makes it clear that we need to develop an alternative to psychiatric diagnosis. The statement was given coverage in national newspapers and radio, was reported beyond the UK, and helped to start a debate on the utility of diagnosis. I believe future markers of clinical psychology making progress would be statements, position papers...
and public engagement which explicitly address social issues and power without providing simplistic and individualistic solutions.

**Final comments**

I believe we need to appreciate the full extent of the horror that many live through in our society, we need to use this motivate us to seek social justice and to consider how we can lend a hand in building a better society. We also need to reflect on how we have hindered progress. When working with an individual, not speaking of specific incidents of abuse might be justified, but practitioners should never free themselves from reflecting on issues of power. Personally and ethically, I believe we have a responsibility to speak in public on issues of abuse, oppression and inequality; the stories we witness urge us to face this challenge and to help give voice to the unspeakable.

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Ethics in contemporary clinical practice

On ‘defensive psychology’: Should we push people who are homeless away or strive to see those who are ‘invisible’?

Suzanne Elliott

‘In situations where people’s ability to spin themselves an alternative narrative to disguise their reality is limited, or where the effects of their material circumstances become too obvious to ignore, psychologists (and of course others) are forced to turn their attention to trying to modify the person’s world rather than the person’s cognitions’ (Smial, 2007)

There are people in all our communities who do not have a permanent roof over their heads; somewhere they feel they belong, a place to call home. We might live or work in an affluent or deprived area, rural or urban, but homelessness is there if we choose to look.

There is no accurate figure for homelessness prevalence, but our service estimates there to be over 1000 people who are homeless in the city in which I work. A small minority are ‘roofless’, literally living on the streets. A larger group, but still a minority, are staying in hostels, refuges, supported housing or other ‘temporary accommodation’. A great many of them will be ‘hidden homeless’, people who are staying on a friends’ sofas, staying with family until they get things together, living in overcrowded accommodation or have taken illegal accommodation as part payment for employment in the underground economy.

Unless we take the care to look, these people are invisible. You may have noticed when you have been around people who are homeless that many do not make themselves invisible, at times we have to work hard to ignore them, but ignore them we do. It is an active process on behalf of all of us; people are ‘invisibled’. Ex-homeless journalist Andreou (2014) described the process vividly: ‘I felt increasingly invisible and inhuman, as if the real me was evaporating.’

A striking example of the process in recent years may be the ‘homeless spikes’ that were installed (and then hastily removed after outrage on social networks attracted unwanted media attention) in the pavement outside apartment buildings, banks and supermarkets earlier this summer. ‘Defensive architecture’ refers to the physical measures we take to defend our spaces from graffiti, urination, traffic and car parking or outright attack (Andreou, 2014). The so called ‘homeless spikes’ communicated a ‘don’t stop here’, ‘this is not your space’ message to anyone considering resting on the pavement there. They also communicate a message for us about our own attitudes towards people who have no other stopping place. It says ‘we do not want to see you’. Andreou, suggests that it is possible to read this kind of ‘defensive architecture’ as ‘Not even this bit of earth. Not even for the night.’ It consigns homeless people ‘further out of sight so that the rest may continue to pretend that real poverty doesn’t exist’. It is ‘a moat to keep

Homelessness
is there if we chose to look.
the peasants out’. This ‘invisibling’ of people who are homeless is a problem for all of us as citizens, including us in our role as psychologists. In the same way that ‘defensive architecture’ removes people who are homeless from our line of sight, ‘defensive psychology’ allows us to turn away from the horrors of extreme poverty.

Over the course of the last nine years of working with people who are homeless I have had the privilege of witnessing countless stories of spirited survival. The toxic contexts within which these stories developed have required steadfast and robust challenges from the people I have met. However, these challenges are not welcomed by society and have been used by services across the UK as reason to exclude people who are homeless (St Mungo’s, 2009). I have created a composite story from those told to us recently (Taylor, 2012) in order to illustrate what I mean by ‘spirited survival’:

Having been removed from her family of origin at three, Denise¹ grew up in the care of social services. The care homes in which she was placed were controlled and run by a group of men who were later convicted for sexually and physically abusing the children in their care over a number of decades. After leaving care, Denise found herself in a relationship with a much older man who she simultaneously loved and feared. They had a tenancy together, but the man was extremely violent and controlling; his violence was frequently of a sexual nature and sometimes involved weapons. She was well known to A&E at this time, and frequently took overdoses. The police were called on several occasions. Her partner would tell them that she had attacked him, sometimes injuring himself before they arrived and blaming her for them. There were times when violence was ongoing when the police arrived and the officers had to separate Denise and her partner. At these times, they would both be cuffed and taken to the police station. Unbeknown to the officers, these actions would trigger memories of Denise’s abuse in care; she would experience terrifying flashbacks and would attack anyone who came near her. She was entirely transported back to her childhood and the devastating powerlessness and humiliation that she experienced. She was physically much stronger than she realised, and she would curse the police officers and their families in the most venomous terms. She became suicidal when she was finally left alone in a cell, so the police stripped her and left her in a paper gown. Eventually, Denise and her partner became homeless due to rent problems caused by her partner’s control of their finances and Denise was placed in a women’s hostel: ‘I had heard horror stories about what could happen in hostels… And, the hostel was probably, in… in my mind, in my subconscious. I guess I just thought I was going into the pit of the abyss.’ There were 30 other women living in the hostel: ‘Two of the girls, they used to go out at night time, selling themselves basically. And they – because I’m a fresh person – they were kind of weighing me up, saying how much they could get for me, if I wanted to go out there, and do it.’

After a few months, Denise lost her ‘bed space’ at the hostel because she got into a fight with another woman who had stolen some of Denise’s money. When she was evicted, the hostel agreed to store some of her possessions because she had nowhere to go. She slept under a broken table in a car park behind a casino for several days. When she returned to collect her possessions at a later date, she realised some very important photographs, the only ones she had of her biological family, were missing. In this moment Denise lost part of her history, and felt a loss that she knew could not be replaced. The following week, Denise found out that the local council had turned down her application to be considered for social housing on the grounds that they considered her to be ‘inten-

¹ Denise is a pseudonym and these are the combined experiences and words of several women and men who participated in our research.
tionally homeless’. Her last tenancy, the one she shared with her partner who controlled their finances, had been in her name and it was rent arrears that had prompted the eviction. She put a brick through the council’s head office window that evening. Needing to keep herself safe on the streets, she found herself befriending a group of other homeless people and begging on the streets; they were frequently the target of verbal and physical abuse by passers by: ‘The stigma of being homeless is that everybody thinks you are an alchy, a druggie, that you have just come out of prison; you are basically, society’s rubbish. That’s what people think. They are wrong.’

It seemed to me that no matter how awful life was to Denise, she persisted. This story cries out survival and resistance, and where there are acts of resistance there is hope (Wade, 1997); the seed of an idea that things could and, perhaps, should be different. Drinking and overdosing are signs that someone is trying to distance themselves from the horror of their lives in recognition that things need not be this way. For a woman, fighting, shouting, swearing and acting in other ways which defy traditional stereotypes of femininity can be an act of self-preservation, warding potential attackers away, but could also be read as an expression of outrage against the system which has let her down so badly and a seeking of justice.

It may be that there are obstacles that obscure our view of people who are homeless. We may need to ask ourselves: ‘What is it that I cannot see here?’ and seek out others who may have clearer vision; those who are, as an ex-homeless research participant described to us, ‘at street level’ (Taylor, 2012). However, it is also important to be mindful of the way we interpret what we see.

Psychologists have a range of techniques to draw from in their efforts to turn away from homeless people. Our individualising, psychologising discourses provide a solid foundation for these techniques. We can tell ourselves that our mainstream mental health, learning disabilities, drug and alcohol, and head injuries services are open to anyone who meets the criteria no matter what their housing status, and therefore to reach out to homeless people specifically is not necessary. If people struggle to attend their appointments because they got evicted, raped, drunk, arrested, beaten up or kicked out of the family home the day before, we can tell ourselves (and perhaps others) that they need to ‘take responsibility’ or ‘think about their priorities’ or ‘stop drinking’ before we can offer them any further appointments. We may decide that we are unable to offer a psychology service because they don’t engage, they are not ‘psychologically minded’ or ‘it’s all drugs and alcohol’ or because ‘it’s PD [personality disorder]?’ or because ‘it’s all behavioural’. Our individualising approaches lead us to assert that these people need to gain ‘insight’ and draw on some ‘inner strength’ or ‘resilience’ in order to reach a position of readiness to use psychology (Harper, 2014). We could even pull out Maslow’s hierarchy of needs to declare that surely someone should have a roof over their head before they can address any of the reasons they are distressed with a psychologist?

Surely someone should have a roof over their head before they can address any of the reasons they are distressed?

The problem of invisibility may be convenient at times; it is almost certainly less painful for us not to see someone who we as a society have abused and neglected for decades, sometimes generations. If we do not see, we cannot give our ‘spare change’, buy a copy of the Big Issue, offer social housing, extend our offer of psychological therapies, support agencies representing people who are homeless in our communities, or campaign for social change. If we do not see, then none of this can be ‘our responsibility’.

I recently witnessed disbelief and incredulity from staff supporting people who are homeless in response to the idea that there could be any benefit to society of turning away in the ways mentioned above. In this moment I could hear David Smail’s words about the dimly lit outer-regions of our power horizons and the powerful interests there that keep us ‘in the dark’. The discipline of clinical psychology may as yet not have ‘insight’ into it’s own
relationship with this part of the power horizon. As Harper (2014) observed, we are not too comfortable reflecting on and identifying the interests of our own discipline. Smail (2007) warns that when we illuminate these ‘stubbornly entrenched’ interests we are ‘challenging deeply embedded cultural assumptions’.

Harper (2014) identifies that psychology individualises distress because as a discipline we are interested in individuals. Our interest in individuals fuelled the growth of the therapeutic industry, and when we challenge individualism in psychology, we are leaving ‘less room in the world’ for individual therapy (Smail, 2007). However, becoming less interested in individuals does not necessarily mean being less helpful. If we consider people who are homeless in the context of our social and material world, our discipline may turn towards the idea that our contexts can both inhibit and promote agency. We may then be more inclined to attend to our collective ‘responsibility’ or ‘agency’ as a discipline to work at a macro level. We might also ask ourselves how we can make our services and settings promote agency and refuse to repeat the damaging practices of exclusion that have become an ordinary, taken for granted part of life for people who are homeless.

In 2008, the General Assembly of the International Union of Psychological Science adopted the Universal Declaration of Ethical Principles for Psychologists, which is organised according to four principles:

The first is ‘Respect for the dignity of persons and peoples’ and challenges us to practice in a way that acknowledges ‘the unique worth and inherent dignity of all human beings’. This suggests to me that we should not be turning away from anyone, no matter how challenging they might be to our systems and models. The second principle is ‘Competent caring for the well-being of persons and peoples’ and includes ‘active concern for the well-being of individuals, families, groups and communities’ (my emphasis). Even when we find it difficult to see them, there are people in our communities who have been invisibled who have as much right to our support as anyone else. In respecting and caring for ‘peoples’, we also have a duty to fix our attention on our communities, joining with others to promote more equal and just ways of living together. This, it seems to me, offers much more room for optimism for us all in that it allows the possibility that the flow of poisonous abuse running throughout our communities might be curbed. Working in this way may challenge our services and our discipline of clinical psychology; in the current climate it is certainly exhausting and our efforts may not always be welcomed by those defending the status quo, but if we work in collaboration and approach the work with even a fraction of the spirited survival I witness in my work with people who are homeless, we stand a good chance of making a difference.

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SERVICE USERS hope that psychological therapies will help them to feel better. Though challenging and controversial, there are signs that routine outcomes monitoring can be used to evaluate and improve therapy effectiveness. In this article, I briefly introduce three national policies in England which I think are ethically problematic and could be damaging to outcomes monitoring. I conclude with ideas for what might be done in response. The guiding principle is simple: outcomes monitoring should be focused on helping achieve its central aim, to learn about and improve care.

Service users hope that psychological therapies will help them to feel better. Though challenging and controversial, there are signs that routine outcomes monitoring can be used to evaluate and improve therapy effectiveness. In this article, I briefly introduce three national policies in England which I think are ethically problematic and could be damaging to outcomes monitoring. I conclude with ideas for what might be done in response. The guiding principle is simple: outcomes monitoring should be focused on helping achieve its central aim, to learn about and improve care.

Providing feedback to practitioners from questionnaires completed by service users seems to improve outcomes (Knaup et al., 2009), especially for people who are showing slower progress than expected compared to norms of change over time (Lambert & Shimokawa, 2011). Examining the content of questionnaires commonly used, it intuitively makes sense why feedback would help. For example, the GAD-7 (Spitzer et al., 2006), used across IAPT services, asks how often people have been bothered by ‘worrying too much about different things’ and ‘feeling afraid as if something awful might happen’. A broad range of questionnaires are available for use, ideally chosen in partnership between therapist and service user depending on the goals of therapy. IAPT services also ask about the care received; for example, whether service users felt listened to by staff. Responses to these items can help clinicians understand to what extent services are helping people who engage in therapy.
It is early days for outcomes monitoring, and the generalisability of evidence to date concerning the benefits of feedback has been questioned (Davidson, Perry & Bell, 2014), but there are some promising signs that outcomes monitoring could improve the effectiveness of therapy. Given the variety of ways outcomes evaluations are used, from branding interventions as ‘evidence-based’ to substantive uses of evidence to try to learn about and improve care, it is important that the ethical implications of outcomes policies are thoroughly debated. In this article, I wish to raise awareness of three national policies in England which I think are ethically problematic. I conclude with some ideas for what might be done in response.

Policy 1: Recommending an unreliable measure

In England, it is now recommended to use a Mental Health Clustering Tool (MHCT) to evaluate outcomes (Department of Health, 2013, p.12). This questionnaire, slightly extending the Health of the Nation Outcome Scales (Wing et al., 1998), is completed by clinicians and covers areas such as hallucinations, depression and relationship difficulties. The MHCT suffers from a very basic problem: the suggested scoring has poor internal consistency. Indeed, this problem was discovered by the people who proposed the approach (Speak & Hay, 2012, p.30): ‘As a general guideline, alpha values of 0.70 or above are indicative of a reasonable level of consistency’. Their results are: 0.44, 0.58, 0.63, 0.57 – conspicuously smaller than 0.70. The authors also refer to previous studies explaining that this would always be the case, due to ‘its original intended purpose of being a scale with independent items’ (p.30). Closer inspection of the individual items reveals why the alphas are so low. For example, the lowest consistency (0.44) is for a two-item ‘Severe Disturbance’ scale which combines ‘overactive aggressive behaviour’ and ‘hallucinations and delusions’ – very different behaviours and experiences, and arguably unethical to put them together in one score. It is striking here that national recommendations appear to ignore the evidence. Once the governmental machinery starts rolling, there is no turning back.

Policy 2: A path to payment by outcomes

Given evidence that collecting regular feedback might improve the quality of care people receive, it seems a good idea that the IAPT programme includes regular progress monitoring using questionnaires which are completed by service users. In contrast to the MHCT, the questionnaires used have adequate reliability. There is, however, another potential difficulty over and above that of the quality of questionnaires used, and that is how external influences such as Payment by Results (PbR) initiatives can change for the worse how data are gathered and used. And PbR initiatives are beginning to be used in practice. The main PbR system under development in mental health is based on predicted need (Jacobs, 2014; Yeomans, 2014). The basic idea is that service users are ‘clustered’ into one of twenty groups of equivalent cost. This, the story goes, should facilitate better planning and more transparent commissioning than is possible with ‘block’ contracts with providers. It also, however, facilitates marketisation and privatisation. IAPT desires something more. The IAPT PbR web page (www.iapt.nhs.uk/pbr/payments-by-results) notes that: ‘An outcome based payment and pricing system is being developed for IAPT services. This is unique as other systems of PbR are activity or needs based.’ Initial pilot results were ‘encouraging’, says the web page, and another pilot is currently running.

The idea with this proposal is that the more improvement shown by service users, as partly determined by outcomes scores, the more money service providers would receive. This is a worry as linking measures to targets has a tendency to cause the measures to stop measuring what it is hoped that they measure. For instance, targets on ambulance response times have led to statistically unlikely peaks at exactly the target (Bevan & Hood, 2006), suggesting that times have been changed. The effect has been around for such a long time that it has a name, Goodhart’s law, describing the effect that ‘When a measure becomes a target, it ceases to be a good measure’ (Strathern, 1997, p.308). This would seem to risk destroying the main purpose of outcomes monitoring (i.e. evaluating outcomes).
Faced with funding cuts, how many staff at already overstretched services will be forced to ‘game’ performance-based payment systems to ensure their service survives? It’s not hard to do; for example, people who drop out of therapy tend to do so because they didn’t think it was helping. It can be easy to justify not troubling people who leave therapy to complete questionnaires. People who stay in therapy and complete questionnaires tend to be the ones who show better outcomes; hence inflating the apparent effectiveness of a service (Clark, 2011, p.321). Another potential problem is so-called ‘power-steering’, whereby, given weekly progress monitoring, therapist and service user may work to decrease a symptom score rather than actual mental health difficulties (Evans, 2012). This might increase if clinicians are under pressure from management to obtain improved scores. It is difficult to see how any data gathered that has been subject to these difficulties could tell clinicians or service providers anything helpful about their services or the well-being of those who use them.

Policy 3: Use of public league tables
There is another problem with how measures are used by adult IAPT. The Health and Social Care Information Centre has for the past few years presented recovery rates – ‘key performance indicators’ – for all services in England in the form of league tables. This has been done without any information on uncertainty, which is highly problematic. There can be vast variability in recovery rates entirely by chance, even if all services are of equivalent effectiveness (Fugard et al., 2014). Funnel plots, well known from meta-analysis, are a better way to present the information and are already used in other areas of healthcare (Spiegelhalter et al., 2012). These take into consideration expected variation in outcomes and focus attention on services with outcomes scores reliably higher or lower than the national average. However, worst of all is the Health & Social Care Information Centre’s presentation of named service data without any context or interpretation. We argue (Fugard et al., 2014) that data always needs to be interpreted in the local service context and suggest that clinicians, and ideally service users, are involved to make sense of differences from national norms.

What can be done?
I think that practice-based evidence using statistically reliable, high quality questionnaires could be helpful in clinical practice, if thoughtfully used in collaboration with service users. A common analogy is that questionnaires are the thermometer or blood pressure measurements of mental health care: providing a general overview of health, and helpful when combined with other information jointly explored in a therapeutic relationship. You are not reduced to a blood pressure reading when you go to the GP, and it is obvious that more interaction is needed to understand whether and why something is awry, and to formulate appropriate care. Using unreliable measures – especially when the developers know they are unreliable – is unethical for a national mental health programme. Linking questionnaire scores to payment raises even more complex ethical issues: poorer decisions about interventions could result because those decisions would be made on the basis of low quality, unreliable data. League tables have been known to be problematic for years. So what can be done? Below I offer some tentative ideas for action.

As a first step it seems important to raise awareness of the issues; for instance, at meetings in services. Clinicians and researchers are aware of the challenges of outcomes measurement and solutions. Senior managers and commissioners can be less well-informed. Issues for discussion include: the importance of considering the positive predictive value of questionnaires (derived from sensitivity, specificity and prevalence data) and using reliable change criteria; being aware of Goodhart’s law; giving presentations on recent papers showing the use of practice-based evidence and current directions for research (e.g. Gyani et al., 2013; Lundh et al., 2013; Nilsen et al., 2015).

The loudest political voices at the moment come from the extremes: those who wish to determine funding using outcomes indicators and those who reject outcomes monitoring entirely. A reflective evidence-informed alternative voice is needed. Possible pathways to ensure this voice is heard include:
1. Writing to your MP (e.g. via www.writetothem.com). This, though relatively easy, seems to have a low
probability of changing anything. However, it can’t hurt to increase awareness of the problems and low probability is better than zero. Coordinated action, as supported by organisations like 38 Degrees (or perhaps the BPS?), increases the likelihood of success.

2. Keeping an eye out for, making others aware of and responding to consultation documents. This has been successful in the past; for instance, encouraging the introduction of clinically useful outcomes measures in children and young people’s IAPT.

3. Joining government advisory groups. NHS England and Monitor advertise positions on their websites and through e-mail – contact them to be added to the relevant lists. These are unpaid, time consuming, and frustrating; however, again, they provide an opportunity to ensure issues are at least discussed – a helpful first step.

4. Writing briefing documents which can be used to defend against unethical decisions. This has been successful in the past for helping a service prevent the introduction of Commissioning for Quality and Innovation (CQUIN) targets on outcome scores.

5. Coordinated protests; for instance, only using questionnaires which are useful for evaluation and clinical decisions, refusing to use measures with poor psychometric properties and explaining why. (I am unaware of any attempts to do this.)

These are only some ideas to get started or to react against – I am sure others have additional ideas. Whatever your view on the utility of outcome measurement, I hope I have made a case for political engagement. Service users are most affected by policy, often bearing the burden of questionnaire completion and benefiting or suffering from how analyses are used. We all – clinicians, researchers, and others involved in outcomes evaluations – must take responsibility for ensuring policies are ethical, so that outcomes monitoring can be focussed on helping achieve its central aim: to learn about and improve care.

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Declaration of interest
I am a social scientist and lecturer in research methods at University College London. My training is in computer science and psychology and my current research areas include practice-based evidence. I worked for Child Outcomes Research Consortium, helped develop the outcomes framework for CYP IAPT, and was involved in analyses for a CAMHS PbR project. I attempt to influence national policy concerning practice-based evidence as a member of the Monitor and NHS England ‘Quality and Cost Benchmarking Group’. I have volunteered for a non-directional confidential telephone listening service and been a ‘befriender’ at a psychiatric inpatient unit. More personally, my father experienced depression for much of his life. I also have experience of mental health difficulties and engaged in brief therapy, which I found helpful. I once refused as a client to complete outcomes measures as I felt the results would be used for marketing purposes. This article represents my own inevitably biased views.

References


The ethics of national routine outcomes monitoring policies


**Clinical Psychology Forum 271 – Ethics Compendium**


**Clinical Psychology Forum 271 – Ethics Compendium**


Jacobs, R. (2014). Payment by results for mental health services: Economic considerations of case-mix funding. *Advances in Psychiatric Treatment*, 20, 155–164. DOI: 10.1192/apt.bp.113.011312


**Clinical Psychology Forum 271 – Ethics Compendium**
Consider the following (adapted from Jopling, 2008):

1. Some ingredients in psychotherapy are active and specific to the purpose of the intervention; some are active and non-specific, that is their effect is due to the placebo response which works by ‘rallying the mind’s natural healing powers’. If this idea is reasonable and not logically or conceptually flawed then question 2 and 3 follow.

2. If there are placebo components to psychological interventions, then would clients who are placebo responders know that they are responding to placebos if they had not already been informed about them – or would they remain in the dark?

3. Would placebo response be less if they knew they were responding to placebo rather than the active treatment component?

4. Do we have an ethical duty to inform clients that they may be responding to a placebo or not?

This month’s column turned out to be more difficult than I expected. I thought I would write about the dilemma faced by practitioners when dealing with placebos. In medicine it is apparently fairly straightforward. There is a person in front of you who complains of symptoms and you believe these can be helped by a placebo, and that giving a drug which has powerful chemical effects would be unethical, so perhaps the less unethical thing to do would be to provide a placebo. So the issue is whether or not to tell the patient that they are getting a placebo. An additional issue might be when a doctor prescribes a tablet, do they prescribe one that is brightly coloured in preference to one that is white, as they know this elevates the placebo response of many patients?

This has been addressed to some degree recently in a short study by (Kaptchuk et al., 2010) for people with irritable bowel syndrome which asked whether deception was necessary for a placebo to be effective.

It was a two-group, randomised, controlled three-week trial involving 80 primarily (70 per cent) female patients, with irritable bowel syndrome. Patients were randomised to either open-label placebo pills presented as ‘placebo pills made of an inert substance, like sugar pills, that have been shown in clinical studies to produce significant improvement in irritable bowel syndrome symptoms through mind-body self-healing processes’ or no-treatment controls with the same quality of interaction with providers. The placebo group produced significantly higher mean global improvement scores at both 11 and 21 days and significant results were also observed at both time points for reduced symptom severity and adequate relief; and there was also a trend favouring the placebo group for improved quality of life at the 21-day endpoint. They note, of course, that there are limitations to this study, but it is at least a powerful ‘proof-of-principle’ pilot. They also raise important ethical issues. They say:

In addition to its clinical significance, our study has important ethical implications. As mentioned above, evidence indicates that physicians continue to use placebo treatment without trans-
parent disclosure to patients (Tilburt et al., 2008; Fassler et al., 2010). Our results suggest that the placebo response is not necessarily neutralised when placebos are administered openly.

But in psychological therapy we are faced with a much trickier set of issues – so tricky that I almost gave up! Firstly, and these have implications more widely, there are the studies that have been subject to very respectable meta-analysis as part of the Cochrane Collaboration (Hróbjartsson & Gøtzsche, 2010), which suggests that in the clinical trials that have specifically tested for the impact of a placebo (unlike those where the effect is confused with other possible explanations like spontaneous recovery or regression to the mean) there is generally a very small effect. There are a couple of areas where there does seem to be the potential for a large effect, pain management being one, but on the whole the evidence does not support large placebo effects. However, they say this:

Despite a general picture of low effects, and the risk of response bias and small sample size bias, it is likely that large effects of placebo interventions may occur in certain situations.

So the first issue is to accept, at least for the time being, that placebo effects can be present and can be large in psychological interventions.

The next question to consider was the sorts of things we use as placebos in our research that demonstrates that the treatment involved is superior. When I began thinking about this issue, I accepted that there are interventions we could regard in the same way as placebos are regarded in medical treatment, like the proverbial sugar pill. But is this true? In a recent study (Nelson, 2011) randomly assigned 31 women with cervical cancer to one of two groups. Both groups received usual care. But one group also got six, one-hour telephone counselling sessions with a psychologist who suggested coping strategies.

Nelson took blood samples to evaluate telomere length at the study start and after four months. He also gathered information about the women’s stress response and their overall quality of life, and he was able to show a statistically significant longer telomere length in the women who had the telephone counselling, a correlate of cells not ageing so fast. It is a small study, but one which highlights the powerful effect we can expect from quite small interventions we may otherwise have regarded as placebos.

So the question then becomes ‘are there such things as psychological placebos?’ This is discussed in some detail by the book Talking Cures and Placebo Effects (Jopling 2008).

In the introduction to his book he describes many extraordinary treatments that have been inflicted on unsuspecting patients in the past in the name of good medicine (e.g. crocodile dung, teeth of swine, hooves of assess) and which, in the words of a pharmacologist from two centuries ago ‘serve only as a humiliating memorial of the credulity and infatuation of the physicians who recommended and prescribed them’ (Paris, 1843, quoted in Jopling 2008). These substances were not themselves effective, but in many cases the treatment produced recovery and this was attributed to the dung or swine teeth, rather than the natural recovery potential embedded in the placebo response and when the patient became worse or even died as a result of the treatment, it was attributed to the disease, not the treatment.

So in this context Jopling throws down a challenge to us by saying:

If a psychological treatment is therapeutically effective not because of its presumed characteristics or active ingredients but because of other non-specific factors such as expectancy, suggestion, placebo responsiveness and so forth, then it is likely that there are cheaper, easier and briefer ways to ensure the delivery of these treatment factors than through expensive psychotherapeutic or psychopharmacological means.

He also argues that if the doubts he raises about the clinical, predictive and explanatory power of many psychological treatments is valid, then it is unethical for psychotherapists to deceive the public with false, exaggerated or unsupported claims about therapeutic effectiveness and explanatory success. Probably can’t argue with that.
Now, in the good old days of medical crocodile dung, maybe the concept of placebo may not have been well understood. However, we certainly know now, and if we know, do we and indeed should we, provide information about this process when we work with our patients, as much of the improvement we may see could be due to it?

In his book, Joopling’s main target are the psychoanalytic psychotherapies where he claims that a central thesis of the insight-oriented psychotherapies is that the patient acquires truthful knowledge about themselves that was hidden, and it is this process that results in cure. The process is facilitated by the skilled therapist offering interpretations which point the patient towards ways of uncovering this truth about themselves. He says this is a philosophical issue, not a question of efficacy or whether good outcomes are produced, but the status of the claim from an epistemological point of view. It is important because if we are trading in what he calls ‘convenient fictions’ we have to be comfortable with this and explain this to our patients.

Joopling’s view is that the fate of many of our contemporary psychological therapies will be as ‘relics in the museum of quaint ideas’, and he includes in this:

- Neuro-linguistic Programming
- Thought Field Therapy
- Emotional Freedom Technique
- Rage Reduction Therapy
- Primal Scream Therapy
- Sedona Method
- Entity Depossession Therapy
- Eye Movement Desenitization
- Body Centred Psychotherapy
- Rebirthing Therapy
- Past Lives Therapy.

One final aspect of this tapestry involves the status of placebo’s in research studies. One of the collaborators in the open label placebo study, Ervin Kirsh, produced a number of landmark reports (Kirsch, Moore et al. 2002; Kirsch, Scoboria et al. 2002; Kirsch, 2010) looking at the data submitted to the FDA on the effectiveness of the SSRI antidepressants. There he demonstrated rather clearly that the main effect of the antidepressants could likely be found in the placebo response – or at least not attributable to the active treatment. He also reported that the more depressed you were at the beginning of the trial, the more relative effect the medication had, but a possible reason was a lower placebo response in those more depressed. In his book The Emperor’s New Drugs: Exploding the antidepressant myth (Kirsch 2010) he provides a good summary of the issues and shows that the placebo-controlled randomised controlled trials does not do away with the problem. The reason is that complete blinding is generally very hard to achieve, as both patients and physicians can often guess which they have had – perhaps the side-effects of the ‘active’ treatment give it away. This then makes those patients more likely to respond as more credible placebos are generally more powerful.

This latter point, again born out by much research, leads to questions about those psychological therapies (EMDR springs to mind) where there is a strong potential for placebo effects. The mysteries of waving ones hand in front of a patient having explained the rationale for the approach musters strong expectancy effects. I speak as a trained EMDR practitioner and use it in my practice. The claims for effectiveness are based on small numbers and, looking carefully at the studies, the challenges as outlined above would be cogent (Bisson & Andrew, 2009).

And more recently still, Martin Seligman’s new book (Seligman 2011) has a chapter called ‘The dirty little secret of drugs and therapy’ that, in typically enthusiastic language, sets out the case that most antidepressant prescribing is not effective and that the gains from most therapy, whether medication or psychological, over placebo are relatively small. He says:

This 65 per cent number crops up over and over, whether you are looking at the percentage of patients that gain relief or at the percentage of symptom relief within patients. I call this problem the 65 per cent barrier.

He advocates changing our approach from providing relief (palliative) to flourishing (cure). And, in passing, this is a very interest-
ing book with an extraordinary account of the extensive carefully conducted studies in positive psychology in recent years.

So, as a profession, should we in our guidance on research be including information about the specifically psychological issues that may call into question the validity of the design and implementation of a study when placebos may have strong direct effects, and also that people can guess what they are. And should we try to work out what is placebo and what isn’t and tell patients?

Which brings me to a few conclusions about all this, recognising that it is a complex and difficult area, both scientifically, philosophically and ethically.

I think it is best summarised in a paper by another colleague (Noon, 1999). In this paper he argues that we have misunderstood the problem, and in many ways raises a philosophical point that Jopling might appreciate. His view is that the placebo response is not just an inconvenient by-product of our interventions, but a real and potent source of healing and recovery and that central to the effect is the interaction of the patient’s and the clinician’s beliefs in the efficacy of the process of healing. He then says:

>This permits a redefinition of the placebo effect in terms of the therapeutic alliance and a shift of emphasis away from the passive treatment of susceptible patients by clinicians to the mutuality of what is termed a joint ‘credebo’ effect.

This may get us off the hook to some degree, but would not absolve us from being open about it. In the trial described above, the doctors said that the placebo often helped, so they tied in giving it with a belief that it had helped – which was true, no deception involved. So to be open about the fact that the better the patient and therapist get on and have a common cause, the more likely improvement will occur, is no bad thing.

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Acknowledgments

Richard Pemberton provided the impetus for this column by telling me about Jopling’s work and also by discussions we have had over recent months about branding of psychotherapies (see Tyron, 2005, for discussion of this issue.

References

DISGUSTING’, ‘appalling’, ‘inhumane’, ‘shocking’ and ‘unbelievable’ are all words that have been used in reaction to the BBC Panorama programme in May this year, in which an undercover reporter exposed abusive practice in a privately run unit for people with learning disabilities. As a fellow human being I found the content of the programme incredibly hard to watch. To see people being treated with such contempt and disregard was painful. Knowing that the individuals were unable to speak out, because of their subordinate position in relation to those allegedly caring for them, now invites critical scrutiny about their shared organisational context. Also, what of the external agencies that should have been protecting these individuals: what function and powers do they actually have? Were they complicit, as implied in the programme, with the continuation of abuse because of a lack of investigative ability? Do they understand how abusers coerce their victims into silence? Why did it take an undercover reporter to expose the abuse when warning signs were apparent?

In the months leading up to the expose a member of staff had been convicted of assault. This does not appear to have deterred the staff at Winterbourne View from continuing with their abuse of the people in their care. It could be that they had become so socialised to their punitive work patterns that they had begun to see their behaviour and actions as ‘normal’. However, a counterargument is that they were aware their work practices were not within ‘normal bounds’. They were caught on film discussing how best to record their actions in a way that did not reflect accurately what had happened and implicated client behaviour as justification for their actions. How a person’s behaviour could ever justify being drenched and left outside in the cold to the near point of hypothermia, or being trapped under a chair with their hair being pulled, or fingers being pushed back or trodden on is a question one would hope is put to the staff when they are taken to court for their actions.

Another warning sign was an ex-member of staff alerting the Care Quality Commission (CQC) about what they had witnessed whilst employed at Winterbourne. A CQC inspection team was sent in several times in the months leading up to the Panorama programme, so why was nothing seemingly uncovered or addressed? One explanation could be the methods inspection teams use, which rely on case care records and an inherently flawed method of evaluating care. Reliance on reports from staff (in whose interest it is not to accurately record their actions) is inherently problematic. However, does this mean that all records made by staff should be treated with the same suspicion? What about within our own profession? This illustrates how individuals whose intentions that are less than honourable can quite easily abuse the power they have been afforded by the title/position they hold. It is a reminder to us all of our power...
and thus our moral responsibility to conduct ourselves with integrity at all times and to be vigilant about events around us when we witness the abuse of power by others.

Another inspection method – interviewing clients – is also a potentially flawed process. People with learning disabilities have a long documented history of being an oppressed minority who often struggle to be heard (Brigham et al., 2000). To engage in an interview process requires the individual to trust the interviewer with the information given. Given the clients’ experiences at Winterbourne View were with staff from ‘mainstream society’, why should those clients trust other people from ‘mainstream society’ (i.e. CQC inspectors)? For inspection data to be trustworthy, we need to be confident that those supplying it are acting in good faith (staff records fail in this regard) and that they have confidence in inspection teams (who cannot take this for granted when taking client accounts).

The latter challenge was acknowledged within the Cornwall and the Sutton and Merton inspections (Commission for Healthcare Audit and Inspection, 2006, 2007). What these inspections uncovered was shocking and led to a national review of services for people with learning disabilities. I have been very fortunate to have met and worked with Karen Flood, a person with learning disabilities who was a member of the inspection teams for both Cornwall, and Sutton and Merton. Having spoken with her about her experiences, I feel that she was probably the most valuable inspector on the teams. She was able to speak with clients in the inspected services and, I am partly assuming because of her belonging to the same group, clients opened up to her. Interestingly, many of her most important and insightful observations of the services came from staff treating her in a similar way to the people in their care, which was different to how they interacted with other non-learning disabled inspectors on the team. Maybe they saw her as less of a threat?

I was disheartened to hear from Karen recently that inspection teams are considering not having a representative from the client group on their panels. (It is unclear whether a person with learning disabilities was included on the CQC inspection teams at Winterbourne). If this is the case then I would urge them to reconsider, as part of a wider review of the methods they employ when carrying out inspections. Inspection teams need to employ several methods to inspect where there are concerns as abusers are very good at concealing their behaviour.

So why should we all be concerned? Well, on a human level the fact that people are still suffering such inhumane treatment in a supposedly civilised society means we should all be vigilant to protect vulnerable people in our midst. Our privileged position as psychologists working with vulnerable people means we should be earnest and proactive in bearing this responsibility. We should be offering psychological understanding in organisations, such as the CQC, to improve inspection processes by promoting understandings about how abuse and neglect develop and are maintained. Without that ethical commitment from us as professionals that we may be unwittingly complicit in scandals like those exposed by the BBC Panorama programme.

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The complicated topic of suicide and sudden unexplained deaths came to mind because of a couple of recent media reports on the same day. The first was about an anorexic woman who wants the right to die, with that request being challenged by health authorities wishing to coercively feed her. The other was of a talented young cricketer, who was found dead on a rail track after fleeing the police, who had apprehended him for driving erratically in the early hours. In the latter case, for now, this is a mysterious sudden death and so the reports are of shocked eulogies about a wasted young prospect.

What is obvious in relation to sense making about suicide is that nothing is obvious, at least at the individual level. Those left after the event can be totally bemused and angry at an explosive inexplicable event in their lives. Alternatively, they may quickly concede that the lost person was understandably at risk for one or more reasons. There are all stops of understanding in between, and being wise after the event in particular circumstances is still ultimately guess work. ‘Psychological autopsies’ favoured by some psychiatrists seem to me to be a bit of grandiose disciplinary opportunism. From the time that psychiatry moved into district general hospitals, it has shown the naked desire to be a proper authoritative speciality; doing ‘post-mortem examinations’ is par for that particular medical course. But I am not sure how they have advanced our understanding of this complicated topic.

Murdering one’s self, when usually we are driven by a mixture of biology and acculturated duty to stay alive as long as is feasible is a gauntlet not so much thrown down to as slapped across the faces of all those left behind. Generally, the latter are in a terrible state of anguish of guilt, anger, remorse and confusion. And so we find social administrative formulae to lessen the chances of this collective pain. One option was to make suicide a mortal sin (the Catholic Church does not do half measures when it comes to sex and death). The other was for the State to declare it to be illegal (historically with theological arguments shaping legalism). A ‘thou shall not’ approach was never likely to be particularly effective in the face of individuals who, at a critical moment in their lives, were intent on doing exactly what they wanted. A defiant transgression of this magnitude would rarely be prevented by authoritarian approbation.

This defiant scenario meant that for an existentialist the act of self-murder could paradoxically be offered as the ultimate act of freedom, even if a cowardly one. For Camus and Sartre, this was a choice to reject the absurdity of life and one with an absent or indifferent god. Rather than opting to stay alive, the (genuine rather than accidental) suicidal person is choosing the ultimate escape route from their unbearable life circumstances. Modern existentialism is at odds though with Confucianism and Stoicism, which viewed suicide, in some circumstances, as brave and hon-
The ethical ramifications of suicide

In traditional Japanese culture this honourable connotation of suicide is at its most obvious, but historically, it could also be found in our own gentlemanly virtue of ‘falling on one’s sword’. Little trace of this seems to remain in our current political class, even in its metaphorical form.

With this philosophical confusion in mind about vice and virtue, whether painted into an existential corner by external forces or inner ‘wrong-headed’ agency, or some combination, suicide ends a particular and very personal predicament. Because the act has been connoted as being as much about freedom as the transgressions of sin (for the Church), pathology (for psychiatry), or risk (for the State), it has attracted particular political and ethical attention.

If we have the right to die at our own hand, should we all have that right? If not, then why not? Surely a right is a right and if it is overruled by another ethical premise, then the latter should be very clear and defensible (Singer, 1987). Under what specifiable circumstances can and should others step in to deny a person their right to suicide? Which of those powers should be formally codified and permitted lawfully by the State? In the case of mental health services, do we simply assume that all people with a diagnosis of mental health problems have no capacity to make a judgment about ending their life?

My view of current risk minimisation efforts in services is that the answers to these questions are more implied than articulated, as the anxiety-laden pragmatics of risk management dominate policy. Those working in clinical services are at the sharp end of all of these tough questions, which are disguised too readily by the social administrative safety mechanisms noted above. In-patients on acute or secure ‘mental health’ wards will find themselves subjected to protocols of surveillance under closed systems conditions, with access to environmental means to self-violence being removed.

This culture of anxious concern has some consequences. First, it privileges risk minimisation above ordinary human relationships. The patient is observed as an object of risk not as a subject with felt needs and due rights and responsibilities. It is an active communication of distrust, when trust should be at the heart of all healthcare interventions (Pilgrim et al., 2010). Second, the moral focus is on the patient’s success in their intentions at the expense of the staff’s failure to prevent that intention. Thus, in a sense, both parties are on trial and a battle of power is ensured. Third, this individualistic focus means that the context of prospective self-destruction, both inside services and outside, can be closed off from analytical consideration.

These complicated and tough implications of suicide prevention in services are explored by Spandler and Poursanidou (2010), with the second author providing a personal account of being sectioned and put on special one-to-one observations. She recalls a contradictory scenario: on the one hand, she was watched in silence by a magazine-reading staff member; on the other hand, she managed to escape twice from her controlling ward regime.

Their paper makes the fair point that these impersonal and inefficient routines of surveillance are the tip of the iceberg about the ethical and legal contradictions involved in practice about suicide prevention in acute services. The wider social context of these routines includes the Supreme Court ruling in February 2012 that NHS psychiatric hospital staff must protect all patients from committing suicide. This now covers voluntary patients not just those on civil sections of the 2007 Mental Health Act. This, at least, eventually recognises the negligible distinction that has been made in practice for the past thirty years between the two legally-codified groups.

‘Voluntary patients’ are not only in a minority now in acute services (the reverse of thirty years ago), they are often subjected to coercion and interpersonal ‘leverage’ (Rogers, 1993; Szmukler & Applebaum, 2001). This reinforces the argument made by Szasz (1963) that as long as we have mental health law, we will never have a genuinely voluntary in-patient. Not only are voluntary patients often threatened with formal status (and therefore...
David Pilgrim

are ‘pseudo-voluntary’ admissions in truth), they are kept on wards that are locked and under special observation, in case they might harm themselves. In what sense then are these patients ‘voluntary’? Surely they are de facto detainees.

Risk averse services will only succeed in their implicit or explicit organisational goal by inevitably increasing their levels of coercion. So what starts as an apparently beneficent sentiment from the Supreme Court, about ensuring the ‘right to life’ of all patients, ends up creating an anxiety-driven mental health service that is not patient-centred but risk-centred. This blanket policy about all patients who might be at risk contradicts the goal of providing a ‘least restrictive environment’ for people with mental health problems.

Moreover, this approach to risk reduction disproportionately draws limited resources into a one-dimensional form of ‘care’ (subverting its true meaning). It also draws our analytical attention away from the context under which risk arises. Public services, including mental health services, are being subjected to resource constraints under the recent recession, undermining further their capacity to be therapeutic environments rather than risk containers. The recession has merely amplified an existing trend of risk-focused decision making by professionals; it has not created that scenario, which has been present in acute and secure settings for decades.

It is fair and accurate to note that diagnosed mental disorder is a risk predictor. However, it is ambiguous whether this arises from the primary symptoms of distress or from social rejection and anomie, with various combinations in particular cases always being possible (Borges et al., 2008; Kessler et al., 1999). Moreover, there are other relevant predictive factors working independently of mental state, including poverty, male gender, employment status, alcohol abuse, ready access to lethal substances and weapons, terminal illness, experience of recent violence (given or received), and suicidal action in immediate family and friendship networks (Platt, 1984; Jenkins et al., 1994; Scourfield, 2005).

These factors beyond mental state require social policy solutions (and resources), which imply more than the narrow ability of courts to direct all psychiatric staff to act in a more controlling manner towards all patients. They also imply that suicide is not in and of itself a robust proxy for mental ill health, even though many psychiatrists, politicians and the mass media frame it thus. Suicide is not inherently a pathological act: what it is, case by case, needs to be argued about from many angles. ‘All suicides reflect mental disorder’ is a preemptive construction.

Moreover, given that most suicides in psychiatric patients occur after they are discharged from hospital, what is implied is a re-think of how they are supported in community settings (Hunt et al., 2009). Open crisis centres and supportive and accessible environments are implied, not more legally-demanded and anxiety-driven medical in-patient units.

And at the end of all this widening of our analytical lens about risk to self, we are still left with the fact that some people will kill themselves; sometimes inexplicably, sometimes not. It was ever thus, and in individual cases we will still be left with some combination of bemusement, sadness, remorse, guilt and anger. We cannot eliminate these risks completely and current efforts to do so, based on regimes of greater surveillance and coercion, simply shift the ethical bulge from the problem of suicide to the problem of an excessive constraint on freedom of human action.

The utopian aspiration for risk elimination is a sure formula for a dystopia of impersonal care and ubiquitous mutual distrust between staff and patients. With this overarching risk in mind, surely we should all be very clear about any policy that is directed at reducing suicide and our participation in those policies.

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...suicide is not in and of itself a robust proxy for mental ill health...
The ethical ramifications of suicide

References


I HAVE BEEN INVOLVED in a training programme as part of the Improving Access to Psychological Therapies (IAPT) rollout of support for people who have medically unexplained physical symptoms (MUPS) and/or long term conditions (Bray, 2009; IAPT, 2012), which was led by Professor Dave Richards. This brought together low intensity IAPT staff with practice managers and nurses. It was a fascinating day, with a very useful exchange of ideas on how best to help people who we know are often in a distressed state. The discussion with people I met on that day made me consider again the ethical issues that lie at the heart of working in this area – not so much in the area of long-term conditions, but for those with the MUPS label.

I also reflected on whether there was anything that psychological science could offer as a way to mitigate some of the risks of unethical practice.

The figures for the scale of the problem are quite remarkable. Looking at the IAPT website, they say: ‘MUS are common, accounting for as many as one in five new consultations in primary care...’

The vast majority of MUS, such as pain or irritable bowel syndrome, have no obvious cause and often do not actually require any input from health services. However, studies have shown that between 20 and 30 per cent of consultations in primary care are with people who are experiencing MUS and have no clear diagnosis. It is estimated that this rises to an average of 52 per cent in secondary care, where a substantial proportion of secondary care resources are used by those using services but whose symptoms remain unexplained.

People suffering with MUS are sometimes described by health professionals as somatisers, but this term is often very unpopular with patients as it implies the MUS are related to a psychiatric disorder, which may or may not be present. However, up to 70 per cent of people suffering with MUS will also suffer from depression and/or anxiety disorders. This is of significance because these mental health disorders are detectable and treatable, irrespective of the explanation for the physical symptoms.

So it is clearly a major problem. Over-investigation has its own price, as does treating the problem as not requiring further study. In any event, the ethical question that I think needs to be addressed are twofold:

Is it ethical, as these are ‘unexplained’ symptoms (which implies that the practitioner concerned is not able to understand or explain the problem), to ‘pretend’ they do understand them, running into the ethical trap of working beyond their competence (e.g. Standard 2.3 (BPS Ethics Committee, 2009) and does the process by which the patient becomes identified as having a MUPS have ethical problems?

The majority of ethical codes state that the practitioner should not work beyond
their level of competence. In the case of these unexplained symptoms there is a paradox. If they cannot be explained by the practitioner then it logically follows they are working in territory that is not within their expertise.

What can psychological science offer here? Well one well-known cognitive bias, sometimes called the Dunning and Kruger effect, which bears on all this, is being overconfident in areas where your competence is low (Kruger & Dunning, 1999). As noted above, where the patient’s experience cannot be explained by the practitioner, they are working under circumstances where they can chose to act as though they were competent or admit they don’t know what they are doing. In my recent experience, there is a strong tendency for the former, and for this to be expressed in a remarkably confident fashion.

Another example of bias can be found in the work of Daniel Kahneman. In Chapter 19 of Thinking, Fast and Slow, entitled ‘The illusion of understanding’ (Kahneman, 2011), he develops the idea of a ‘narrative fallacy’ which describes how ‘flawed stories of the past shape our views of the world and our expectations of the future’. He draws on the work of Nassim Taleb whose book The Black Swan should be required reading for those whose confidence exceeds their competence (Taleb, 2007). The relevance here is that many practitioners work on the principle that ‘when you hear horses think of horses not zebras’, and therefore rule out unusual explanations for people’s conditions – sometimes it might actually be a zebra, or indeed a black swan (that is, a serious illness). A couple of my favourite books, both for the practitioner and the patient, discuss the fascinating research field on gullibility (Greenspan, 2009; Law, 2011). Why do we accept explanations as we do? The remarkable capacity of human beings to believe amazingly unlikely things is extraordinary, and Greenspan and Law both give an insight into how this works psychologically and how you might avoid it.

Also important is how professional staff communicate with patients about their problems. In the thoughtful paper mentioned above, Peter Salmon, Professor of Clinical Psychology at Liverpool, discusses the way the authority of the professional and the authority of the patient can come into conflict (Salmon, 2007). This concept of authority nicely encapsulates the problem in an area where the symptoms can’t be explained by the professional, and the patient probably has a number of possible explanations and is trying to work out which one is the most likely – and also what the implications would be. In fact, the practitioner also has explanations, sometimes made manifest in empty diagnoses like ‘globus pharyngeus’ – the feeling of a lump in the throat, and often derived from narrative fallacies in the area of hysterical conversion. Salmon argues that:

These symptoms are problematic for Western medicine, too, the success of which is founded on reductionism: symptoms are attributed to diseases, which doctors then treat. Practitioners find it frustrating to treat patients with symptoms that they cannot attribute to disease and that often do not respond to treatment. Medicine has therefore tried to fit these symptoms into its reductionist framework by creating disease concepts to which to attribute them. Many patients are told that they have a functional disease, such as fibromyalgia, chronic fatigue or irritable bowel syndrome, with the implication that the disease explains their symptoms. The reasoning here is circular, however – the evidence for the disease is the symptoms, which are then said to be explained by the disease. (Salmon, 2007)

This epistemological status of MUPS is interesting. In much research they are described as ‘functional’ (Richardson & Engel, 2004; Stephenson & Price, 2006; Wessely, Nimnuan, & Sharpe, 1999). Now, what does ‘functional’ mean? Generally speaking, it means that whatever you are saying is functional, has some purpose. That is, in this con-
text, the symptoms have some sort of purpose. This is old psychobabble language in my view. The more honest ‘medically unexplained’, however, does not seem to mean there is a problem which is beyond the ability of medicine to explain, rather there is an implication that the person with the experience has something that probably they have caused themselves.

A final bias – sometimes referred to as the ‘self-serving’ bias (Campbell & Sedikides, 1999), where the practitioner may credit themselves for any recovery and the patient for any deterioration.

So far it has been assumed that ‘unexplained’ means unexplained by the medical profession, and hence a failure of physical examinations to identify any physiological pathology. Indeed, from a Cartesian perspective, medically unexplained mental symptoms (MUMS) might also be invoked for many psychological problems that people have, but for whom psychiatrists can detect no physiological malfunction! (G. Turpin, personal communication, September 2012).

Hence, when the person is seen by a psychologist or psychotherapist, different models of explanation are offered for the symptoms other than physical/medical ones. We do offer plausible explanations – whether they are accepted by the client is another matter. Maybe here we are working beyond our competence?

In addition, psychologists have a long tradition of making up stories about the problems their patients have and attributing them to psychological processes which may be figments of their imagination (Jopling, 2008), so we need to be cautious not to be over critical of colleagues.

In conclusion, for psychologists working in and around this field, they need to take extra care that they do not fall foul of some of these processes. They also could also work with their other healthcare colleagues to draw attention to some of the pitfalls and ethical issues that can arise.

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The American Psychiatric Association (APA) has given up on Roman numerals and we are now in the eye of the storm about DSM-5 (www.dsm5response.com). One controversy has repeated about the iterations of DSM and has particular ethical implications. At its heart is a fundamental question: ‘If psychological differences are discerned by experts, does this signal scientific and social progress?’ And a subsidiary question that leaps at us in its wake is ‘progress for whom?’.

In an editorial in the Journal of Mental Health, which anticipated the DSM-5 debate, Til Wykes and Felicity Callard warned of a post-2013 when ‘the pool of “normality” shrinks to a mere puddle’ (Wykes & Callard, 2010). This warning can be read in at least two different ways. The first is that some people are legitimately labelled as being psychologically abnormal but others are not. The second is that it is better for any of us to be defined as normal in principle, as it is will be a safe haven from persecution at the hands of those who are sane by common consent. This scenario reminds us of Mrs Winterson’s question to her stroppy lesbian daughter, ‘Why be happy when you could be normal?’ (Winterson, 2011). But it also reminds us of the early debates about ‘unfair detention’ in Victorian lunacy legislation (Bean, 1985); more on this below.

The drug companies and biological psychiatrists that have collusively foisted DSM-5 on a suspecting but undeserving world are quite happy to invent more and more categories that are the potential targets for ‘magic bullets’ to be marketed (Pilgrim, 2007; Lakoff, 2005).

This collusive compact was consolidated in the 1970s and ensured the dominance of the neo-Kraepelinians inside the American Psychiatric Association, to ward off competing approaches from psychoanalysis and Meyerman social psychiatry (Wilson, 1993; Bayer & Spitzer, 1985). The invention of ‘panic disorder’ meant that the drug companies could rebrand and sell older stocks of some antidepressants (Healy, 1997). Similarly the medicalisation of shyness meant that a drug might cure ‘avoidant personality disorder’ (Scott, 2006; Lane, 2008).

There are some exceptions to this trend. The removal of homosexuality from DSM in 1973 is the best rehearsed example. Even in the current expansion, one category is to be substantially trimmed (but not removed). Changes in the wording about ‘dissociative identity disorder’ (DID – under ICD, ‘multiple personality disorder’) means now that where local cultural norms could explain its symptoms, the diagnosis should not be invoked (Saville-Smith, 2013). At the stroke of the APA pen, thousands of people internationally will no longer be mentally disordered. But this dramatic exception is still an exception. Presumably, the criminals who plead DID to exculpate their sadistic murders and rapes will still be listened to and their paid experts recruited (Crego, 2000). And self-generated DID celebrity will presumably persist (Oxnam, 2002). As they say, ‘only in America’.

In this context of contention, is clinical psychology as a profession truly and comprehensively committed to rejecting DSM (or for
that matter ICD) in principle? I have felt for many years that the profession’s response to the hegemony of psychiatric diagnosis has been at best ambivalent and at worst intellectually flaccid. A whole generation of successful academic clinical psychologists has pursued research into CBT for ‘schizophrenia’, ‘panic disorder’, ‘PTSD’, and so on. Crumbs, sometimes large, sometimes small, from the funding table of medicine, have come its way.

Look back at the contents of the British Journal of Clinical Psychology or even Forum (despite editorial guidance) and see how often our colleagues have reported ‘findings’ that keep recycling and re-legitimising diagnostic psychiatry. You name it and it is there. Clinical psychologists not only publish articles about their favourites – ‘schizophrenia’, ‘anxiety disorders’ and ‘depression’ – but we also have ‘schizophrenic’ subjects.

Maybe clinical psychology has still not worked out whether it is or it is not a genuine intellectual alternative to psychiatry. The recent publication of guidance from the DCP about formulation is telling for the very reason that it was published at all (Division of Clinical Psychology, 2011). If the argument for formulation about the socialisation of neophytes in the profession had been won fully, then the document would have been redundant. But the argument was not won and so the document was needed.

Apart from the naïve realism within psychology, which has encouraged an uncritical acceptance of psychiatric positivism (Pilgrim, 2013) there may be other undeclared motives. An obvious one is that, as a profession, clinical psychology remains wedded to therapy, especially in its individualised form. And if the therapy industry is to thrive and expand then it needs clients. We are drifting now then towards the magic bullet logic of the neo-Kraepelinian/Big Pharma symbiosis. If we can frame therapy as an intervention like a drug that curatively attacks a disorder then the trick is completed. If we can collude with an expansion of disorders then all of these newly created patients will require treatment. If, as in the US and Australia, a diagnostic code is required to claim fee reimbursement then the clinical psychologist will tick the box and join the game of diagnosis, creating our very own ‘medical model psychology’ (Johnstone, personal communication).

Whichever mental health tribe we belong to, self-defined by a model of therapy or our core profession, another undeclared ethical context hovers beyond this point, about constructing disorders to warrant therapeutic roles and salaries. This is about the deeper nature of mental health work. Within that lays the very point of discerning psychological abnormality which I flagged at the start. The APA clearly thinks that the more that people are diagnosed, the more that they will be eligible for benign and efficacious medical treatment. This logic is flawed for four reasons.

First, psychiatric treatment is not always benign. It is fraught with iatrogenic risks. Second, it is enacted in settings which deploy or threaten coercion: ‘access’ to help may be imposed, not simply offered in a spirit of true voluntarism. Third, being diagnosed with a mental health problem is inherently stigmatising, as well as confirming and reinforcing lay stigmatisation. Fourth, treatments are not always effective, even if modest criteria about symptom reduction are utilised.

The first and second problems with treatment have been brought into a clear ethical focus in recent times. For example, recently the US Government has been asked by the United Nations Human Rights Committee to clarify how forced medication in mental health services is compatible with Article 7 of the International Covenant on Civil and Political Rights (the obligation to ensure that no-one is subjected to torture and ill-treatment). In a related move, at the General Assembly of the European Network of Users and Survivors in Psychiatry, held in Thessaloniki on 30 September 2010, delegates voted to agree a campaign for ‘truth and reconciliation in psychiatry’. This demanded a formal apology from psychiatry for the damage it has done...
over the past century to its victims. The ethical implication of the third problem is that labelling inherently jeopardises our personhood (Pescosolido et al., 2010; Sartorius, 2002). The ethical implication of the fourth problem is that we may be exposed to iatrogenic risk, when no therapeutic benefit accrues (Moncrieff & Kirsch, 2005).

These doubts mean that we need to interrogate diagnostic psychiatry using ethical, not just epistemological, criteria. If we seek out a label to warrant being helped then we must be careful what we wish for. Will the label help or harm us? And if we enter treatment (whether this is chemical or conversational), will that help us and not do us harm? In the light of the above four problems with treating mental health problems, psychological therapies should be exposed to this interrogation just as much as pharmacological interventions should. Quite rightly, a psychological and not just a medicinal approach to treatment has been brought into question at times. And these doubts also need to be part of our continuous professional reflection and memory, as their intelligent rehearsal can easily be forgotten from one generation to another (Masson, 1988; Zilbergeld, 1983; Smail, 1996). Trainers could ask students if they have any awareness of such critiques; this is might be an illuminating exercise.

Clinical psychology, with its roots in scientific humanism, seems to have both followed the conservative contours of diagnostic psychiatry and objected to those contours (Bentall, 2010; Johnstone, 2000). For example, the formulation document was at least produced, reflecting the efforts and ideology of colleagues who were trying to offer a true alternative to psychiatric diagnosis from their disciplinary perspective. Also, the critical International Response Committee to DSM-5 contains many clinical psychologists (including this author) and the BPS has made its critical position clear (British Psychological Society, 2011).

This is a good time for all of us – but especially junior colleagues and trainees – to think through clearly the ethical basis for our preferred form of practice in relation to labelling, research into and remediation for psychological abnormality. As for senior colleagues, especially supervisors and trainers, they should now make it clear that psychology is not psychiatry and hold that line at all times. Much progress has been made by the DCP in recent years to encourage a cultural shift away from psychiatric diagnosis. However, the struggle continues and it must be informed by ethical and not just epistemological arguments.

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References


Ethics in contemporary clinical practice

Ethics and quality improvement systems

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This special issue on lean approaches to quality improvement contains many exciting and inspirational accounts. It is clear that, implemented well, such approaches can be associated with good outcomes and improved quality from a variety of perspectives. However, the articles also illustrate a point that I want to take up in this column, which is this: While ethical issues are discussed in at least two of the papers in terms of choices that need to be made (e.g. should we have a ‘Rolls Royce’ service that means fewer people get it, or issues concerning not providing therapy) the ethical question about the implementation of the quality improvement system per se is not discussed as ethically problematic.

What are the ethical challenges of quality improvement systems?

While I have not been myself involved in implementing a lean project, this Special Issue on ‘Lean’ provides some examples of how this approach works, and the philosophy and psychology that underlies it. However, in the review of Drew Locher’s book (Locher, 2011) on the application of lean to offices, Craig Knight argues that the implementation of lean described is not based on science or a firm evidence base (see also Andersen et al., 2014; Briner & Rousseau, 2011). There have also been claims that the evidence base for lean approaches, such as it is, is also affected by publication bias, overemphasising its successes (Joosten et al., 2009). Researchers have also pointed out that the benefits of quality improvement approaches might accrue from non-specific aspects of the approach (for example, having a common purpose), while the negative consequences (low staff morale) could flow from its core approach (Knight & Haslam, 2010).

How might we map the four principles in the Society’s Code of Ethics and Conduct (BPS Ethics Committee, 2009): Competence, Responsibility, Integrity and Respect, against what emerges from this account. Clearly, if there is a lack of evidence for these approaches, then taking part in their implementation will suggest caution, as all four principles may be in play. Competence, as the approach is not well evidence based; Responsibility, as there is potential under reporting of negative outcomes; Integrity, as it will be important to speak about these problems; and Respect, as the way we treat staff and patients in a drive for efficiency or achieving targets may breach that principle too.

Organisational ethics is a particular domain of study that concerns the way an organisation functions to either promote or discourage ethical thinking and behaviour that is not explicitly covered in the Code of Ethics and Conduct (Sekerca et al., 2014; Whitton, 2009). The Francis report devoted its third volume to this area, focusing particularly on organisational culture (Francis, 2013) and Professor Charles Vincent, a clinical psychologist, has a very helpful book on Patient Safety, quoted with approval in the Francis report (Vincent, 2010), where he outlines the very good evidence we have on how to establish an effective safety culture (for example, in the aircraft industry’s ‘Just Culture’).
When considered through this lens the main ethical challenges of quality improvement approaches more generally, like lean, is that they are largely lacking in a high quality evidence base and what evidence there is seems to support the idea that there is a risk that they may be ineffective, costly or even harmful, as in the example of the British Standards Institution’s BS 5750 (Seddon, 2008). BS 5750 (also known ISO 9000) is the kite mark for quality developed by the British Standards Institution (see Seddon, 2000, for a useful historical summary and critique). When I was doing my Director of Quality job, this was an approach we were encouraged to implement and I spent a good deal of time looking at how we could apply the various standards to our work. The idea was that you could specify the processes and policies in an organisation and find ways of ensuring compliance, so that there was standardisation in how healthcare in various forms was delivered. We would also seek to only use suppliers who had similarly been certified. In the end, it turned out to be impractical given the complexity of our organisation, and the standard’s general lack of applicability, but the pressure to find similar badges (for example, Investors in People, Mindful Employer) was considerable. That applying these standards was in general a poor idea has some acceptance, as this quote from John Seddon illustrates:

In 1979, persuaded that it contained something of the ‘Japanese miracle’ and keen to improve British management, Margaret Thatcher pushed the button on what was British Standard (BS) 5750. Despite vociferous complaints from managers about bureaucracy, value and relevance, by 1987 the British Standards Institute and UK government convinced the International Standards Organization to adopt BS 5750 as an international standard. We wrought an economic disease across the world. We should be ashamed.

A similar story can be told about the way that lean approaches have been applied, and John Seddon again provides a brief and cogent critique in a paper entitled ‘How lean became mean’ (Seddon, 2010), in which he says:

Instead of changing it, lean unfortunately reinforced management in its current paradigm. As such it represents the further industrialisation of service, with effects that can only be deleterious. Aside from the costs of inefficient service delivery and unhappy customers, lean (like all mass-production management) demoralises workers. Four years into its lean programme, and still experiencing serious performance problems, HMRC reports chronic low morale; while a new book (Stewart, 2009) tells the sad tale of lean’s use, or rather abuse, as another device to sweat labour, about as far from Ohno’s philosophy as it is possible to get.

Within the NHS, one particular area that has become pervasive is target setting. There is no doubt that if you focus an organisation on achieving a particular achievable outcome, it is likely that it will be able to do it. However, as many have observed, there may be unintended (but perhaps not cared about) consequences (Ordonez et al., 2009). In their Harvard Business School paper ‘Goals gone wild’ they say:

Advocates of goal setting have had a substantial impact on research, management education, and management practice. In this article, we argue that the beneficial effects of goal setting have been overstated and that systematic harm caused by goal setting has been largely ignored. We identify specific side effects associated with goal setting, including a narrow focus that neglects non-goal areas, a rise in unethical behavior, distorted risk preferences, corrosion of organisational culture, and reduced intrinsic motivation. Rather than dispensing goal setting as a benign, over-the-counter treatment for motivation, managers and scholars need to conceptualise goal setting as a prescription-strength medication that requires careful dosing, consideration of harmful side effects, and close supervision. We offer a warning label to accompany the practice of setting goals.

In the UK, it often appears that goal or target setting, while leading an organisation to do something that can improve popular sentiment and be politically helpful (and potentially also being useful in itself), may also have
potentially serious consequences that may be concealed. An example might be the aim of getting people off benefits and into work – a laudable aim no doubt – but the process of achieving this is now widely recognised as having been very damaging to our society’s most vulnerable people (Warren et al., 2014). Research also suggests that inadequate employment (e.g. low pay, lack of control high demands, job insecurity) have many negative consequences (Dooley, 2003; Waddell & Burton, 2006) and that those inadequately employed, having to reach targets set from above, may be worse off psychologically than those on benefits.

What might be some ways of addressing these ethical challenges?

As noted above, while our own Code of Ethics and Conduct (BPS Ethics Committee, 2009) does not specifically cover organisation ethics, it can provide a framework for considering how a psychologist might respond to a request to take part in a quality improvement programme. For example, the principle of Competence would mean that unless you have some confidence that the approach has a good evidence base, it would be unethical to implement it. Furthermore, knowing that the consequences of organisational approaches can be problematic from an ethical perspective would mean considering this issue carefully and discussing it with colleagues. Just because an approach has inspirational and persuasive advocates, does not provide evidence that it is right to implement it. A useful account from an occupational psychology perspective can be found in the response of the Division of Occupational Psychology to the Francis report (Tate et al., 2014).

Additionally, there has been some useful work that Derek Mowbray has been instrumental in, where the Institute of Healthcare Managers have adopted a code of conduct for themselves (Institute of Healthcare Management, 2013), so that managers can be engaged in a conversation concerning the ethical questions that management approaches entail. Other organisations that have come under significant scrutiny concerning ethical misconduct have also adopted system-wide approaches to ethics, and one that appears to be thorough is the College of Police (College of Police, 2014).

Concluding remarks

In conclusion, there are a number of points which should be stressed. Firstly, improving the quality of a service is clearly an important task and clinical psychologists are in a good position to help develop evidence-based and values-based strategies for their implementation, and should actively involve themselves in this area of practice. Secondly, just because an approach says it improves quality, doesn’t necessarily mean it does. Indeed some may have the opposite effect. Thirdly, while many approaches have some evidence to support their effectiveness, getting a clear view of how good this evidence is is not an easy task. One good source of information is the Cochrane Effective Practice and Organisation of Care Group (www.epoc.cochrane.org/our-reviews), who have published many reviews, and their conclusions can give an informed insight into the proposed plans. Fourthly, make a risk assessment of the proposed plans so that you can make an informed judgement of the likely benefits and hazards associated with the implementation. This might include opportunity costs, since they are often time consuming and would take attention away from other tasks, possibly more important. Finally, working in this way involves the competencies of the organisational psychologist. The Health and Care Professions Council includes, among others, a specific Standard of Proficiency that is worth bearing in mind: ‘Be able to act ethically to balance the interests of the organisation with respect to individual rights’.

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RECENT REPORTS by Oxfam (2014a, 2014b, 2015a) and newspaper headlines led me to reflect on inequality, wealth and social class, and whether it was relevant to clinical psychology. The data reported on Oxfam’s website was striking: ‘Eighty people now own as much wealth as half the world’s population, while nearly a billion people can barely afford to feed their families’ and ‘Inequality is rising: The combined wealth of the richest 1 per cent will overtake that of the other 99 per cent of people next year unless the current trend is checked.’ (Oxfam, 2015b). The stark differences in wealth, and hence power, should prompt ethical reflection, but such global inequality might seem distant to clinical psychologists practising in the UK. However, inequality has been increasing in the UK since the late 1970s/1980s and wages (taking account of inflation) have decreased significantly during the recent economic crisis, particularly for younger people (Blanchflower & Machin, 2014). Oxfam (2014b) reported that within the UK, the five richest families were wealthier than the bottom 20 per cent of the population. Social inequality, wealth and people’s place and status is relevant to me as a UK citizen; however, as a psychologist do I need to concern myself with social and economic issues? In reflecting on this I looked to the Universal Declaration of Ethical Principles for Psychologists (International Union of Psychological Science, 2008, p.2) for guidance:

Psychologists recognise that they carry out their activities within a larger social context. They recognise that the lives and identities of human beings both individually and collectively are connected across generations, and that there is a reciprocal relationship between human beings and their natural and social environments. Psychologists are committed to placing the welfare of society and its members above the self-interest of the discipline and its members... the commitment of the psychology community to help build a better world where peace, freedom, responsibility, justice, humanity and morality prevail.

My reading of the Universal Declaration is that psychology should give some thought to the issue of social inequality and wealth; in particular, the relevance of these issues to the people we work with. My specialist area involves working with people who hear voices, are suspicious of other people and at times have beliefs others find unusual. Read (2010) in a review of the area asked: ‘Can poverty drive you mad?’, and his unequivocal answer is that poverty is a clear causal factor in mental health, including ‘madness’, mediated through other factors in people’s lives. He also cites evidence that inequality is an even more significant factor. The Marmot Review (2010) and the work of social epidemiologists Richard Wilkinson and Kate Pickett (2010) detail extensive research evidence that social inequality has an impact on a wide range of personal and community measures of well-being.

If social inequality matters, what can I, as an individual practitioner, and the psychological profession do about it? Arguably, psychologists are already intervening; for example, take the contrasting positions of the Improving Access to Psychological Therapies (IAPT) pro-
gramme and a recent campaign, Psychologists Against Austerity. Publications by politically influential and prominent advocates of IAPT, Layard and Clark (2014a, 2014b, 2014c), whilst appearing to be driven by the motivation to alleviate distress, downplay the importance of the impact of the social world on psychological well-being. For example, the articles argue that ‘dealing with the external’ and the ‘enormous progress’ made in areas such as income, education and housing had not addressed psychological well-being and the malaise of industrial nations. Instead, they called for a turn to the ‘inner person’ as the focus of intervention and difficulties solved through the ‘power of evidence-based psychological therapies’. Whilst Layard has discussed issues such as inequality (e.g. Layard, 1999), regarding mental health and therapy, the emphasis is on ‘the huge social cost of mental illness’ (Layard & Clark, 2014b) rather than how social problems cause distress. In short, their perspective on mental health is ‘We have tackled the external problem but not the one inside… the evil of mental illness.’ (Layard & Clark, 2014c).

A campaigning group ‘Psychologists Against Austerity: Mobilising Psychology for Social Change’ appear to hold very different assumptions to those of the IAPT proponents (www.psychagainstausterity.wordpress.com). They directly address how public monies are used in the UK and link cuts in public expenditure to increased poverty: ‘As applied psychologists it is our public and professional duty to be speaking out against the further implementation of austerity policies.’

The campaign suggests links between economic factors and psychological well-being through five mechanisms: humiliation and shame; fear and mistrust; instability and insecurity; isolation and loneliness; and being trapped and powerless. Furthermore, there have been many (e.g. Moloney, 2013; MPG, 2012; Smail, 2001) who have critiqued mainstream psychology and IAPT not only for paying inadequate attention to the social world, but for concealing the relationship between society and its impact on the individual.

There appears to be a marked difference in emphasis regarding wealth and inequality between the IAPT programme and the Psychologists Against Austerity Campaign, and I’m sure others fall on a continuum between. How can we explain such differences? There are many ways we could look at this, from an evidential perspective, theoretical, or in terms of vested interests. However, I want to consider how our personal experiences shape our view of inequality; how our feelings about our sense of position and place in the world shape our attitudes to poverty and wealth. The Universal Declaration of Ethical Principles states that we should have ‘self-knowledge of how one’s values, experiences, culture and social context might influence one’s actions and interpretations’, and we often rightly consider this in terms of ethnicity, gender, disability, sexuality, and so forth. However, I think clinical psychologists need to reflect more on our social class (as well as how this intersects with other aspects of diversity).

The personal background and social class of a psychologist is one factor influencing how much attention is paid to issues such as inequality and poverty, and we need to reflect on how inequality has influenced us and our beliefs. My own experiences, growing up in a relatively financially secure working class family, shaped me and my views of class and wealth. I probably fell in the gap between friends whose families struggled financially and were relatively less privileged than I was, and middle class friends. With middle class families their ways of being at times felt unusual to me: I was unsure of some of the assumptions and rules of interaction, which could leave me feeling uncomfortable and having a sense of not fitting in. These experiences have provided me with a form of knowledge about how inequality shapes people. I witnessed very bright classmates from deprived backgrounds drop out of education due to poverty-related stresses (insecurity in housing, difficult neighbourhoods, etc). I also saw how for many of my middle class friends the main stresses came from being in the eye of a hypercompetitive culture, often focused through heightened expectations of their parents (see Horney, 1937, for a discussion of how culture shapes hypercompetitive personalities). Whilst some friends had material wealth, retrospectively, the 1980s culture of competition, ‘greed is good’ and consumerism provided its own stressors. Being a father in my early twenties and regularly worry-
ing about money problems, such as how to pay the gas bill and the guilt of using money intended for our young son’s birthday, is ingrained in my mind and never to be forgotten. These experiences now give me a sense of empathy for the grind of counting pennies and pounds, and a sense of how it feels to be down-ranked in a culture that places great expectation and pressure on ideals around how we should look, dress and speak, and what we should have and consume. I also had the knowledge that I was lucky in having educational opportunities to escape that not everyone had open to them. I believe my lived experience is a form of knowledge that sits alongside, gives a sense of feeling to, and makes alive my scientific knowledge and theory of how culture, social and material resources shape individuals. I also believe that my experiences oriented me to think about the social world because it was prominent in how it shaped my life and those I cared about. Ultimately, it shaped and motivated my ethical stance to inequality and poverty.

The motivation to address inequality requires empathy and compassion for others. There is an interesting body of literature supporting the notion that our social class and personal circumstances are factors (amongst many others) that shape our attitude to the plight of others. This social-psychological research suggests that those with greater social power (higher social class) tend to have less empathy and compassion towards the distress of others – ‘turning a blind eye to the suffering of others’ (e.g. Kleef et al., 2008; Stellar, Manzo, Kraus & Keltner, 2012; Piff, Stancato, Cote, Mendoza-Denton & Keltner, 2012). The research suggests that those with most power and influence in the world, particularly the super elite of very wealthy people, are likely to have decreased empathy towards the majority, including the impact of social inequality. However, it should be noted that class is a multidimensional concept, and the relationship between class and ethical behaviour is complex, mediated by moral values, and should not be seen as a simple deterministic relationship (Trautmann, van de Kuijen & Zeckhauser, 2013). Despite this caveat, and my assumption that most psychologists are not part of a ‘super elite’, I do believe such research should prompt psychologists to reflect on how class influences our attitudes towards the distribution of wealth, particularly given clinical psychologists are relatively more privileged in terms of income than the average UK citizen, and often have more social power, given our educational status. How does our class shape our empathy towards clients who have less power and status? Does our social status and privilege shape our psychological models? Are our theories and practices blind to the realities of the less fortunate?

My view, based on life experience, evidence and theory, is that social class and the distribution of wealth has a great bearing on the welfare and well-being of the people psychologists try to support. This can be felt through the practical and everyday stresses of living with limited resources. Furthermore, we are all affected, directly and indirectly, by how our unequal and consumerist culture breeds a hypercompetitive-ness and a sense of unrealistic expectation that leaves many feeling ashamed (e.g. Smail, 2001). These issues are of a cultural, social and material nature, which therefore necessitates that we look for solutions beyond individual therapy. Obviously there are restrictions to how, as individual practitioners, we achieve this, and we might be limited by our workplace in how we help the people we work with. However, I do believe we and our professional body need to work towards making the social-material world and the distribution of power and resources core to our thinking and practice. This is necessary if we are to be a profession that: is ‘committed to placing the welfare of society and its members above the self-interest of the discipline and its members’ (p.2); is sensitive and responsive to the local needs of communities; and acts with fairness and justice (International Union of Psychological Science, 2008). As a start, I believe as psychologists we need to:

1. Ensure the social-material world and its shaping of individuals is firmly embedded in our models and formulations.
2. Reflect upon how class and privilege has shaped our assumptions about individuals, society and the distribution of power.
3. Ensure that we are not providing the public and politicians with messages that undermine the importance of social inequality, class and wealth.
4. Develop ways of working that are more sensitive and responsive to the social-material resources and needs of individuals and communities.
5. Write guidance papers for politicians and for the public on the impact of social inequality and its psychological impact.
6. Be honest about the limits of what psychologists can do and be open to the fact that some social ills require solutions that are social and economic in nature.

It is likely to be challenging for clinical psychology to take inequality seriously and will require us to examine our assumptions, our own prejudices and our vested interests. The opportunity is a richer understanding and better ways of helping the people and communities with whom we work. The risk of avoiding the challenge of inequality is that we are part of the problem, rather than part of the solution.

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Declaration of interests
I am one of the DCP’s Ethics Coordinators and the UK DCP Honorary Treasurer. I therefore have a role in the strategic direction of the profession; however, the views expressed are my own and do not necessarily represent the perspective of the DCP.

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References
I N MY personal life I am interested in and concerned about a range of social issues. Unemployment, inequality, housing, deprived neighbourhoods, the impact of austerity and current economic policy are everyday issues discussed and debated in a range of media outlets. These are common day-to-day topics of conversations for people at home, socially and informally at work. Whilst personally important, I feel uncertain about what clinical psychology has to say on these topics. Given the importance of social issues in everyday talk, should clinical psychology have a voice?

The DCP suggests ‘social factors such as class, poverty, unemployment and power relations’ are ‘sometimes neglected or downplayed in clinical psychologists’ formulations’ (DCP, 2011, p.14), and gives an unambiguous message that social causes should be included within psychological formulations. This guidance is clearly warranted given the wide range of social factors found shaping people’s well-being and emotional distress, such as: inequality, community cohesion, discrimination, poverty, unemployment, inadequate employment and poor housing (Friedli, 2009; Melzer et al., 2004; Wilkinson & Pickett, 2009). Within our individual work there are tools which can help understand how social-material resources shape people; for example, power-mapping (Hagan & Smail, 1997). Still, should we go further than just individually formulating social issues?

My brief search of DCP guidance and occasional papers did not reveal any clear titles addressing social issues. This led me to reflect on whether this was justified: Is this an area we should be providing an informed perspective on? Would commenting on societal issues as a profession go beyond our remit or competence? If the profession acknowledges and accepts the importance of society, are we ethically remiss in not speaking up? Do we have something to contribute to ongoing public debates?

I feel we have a privileged position in hearing people’s experiences of pain, shame and hurt, as well as resilience and strengths, and a role in connecting these experiences to the multi-faceted contexts of people’s lives. A social perspective in the form of data and figures on poverty, whilst vitally important, can become arid and abstract – the data connects with the head, but does not inspire the heart. So can we add something new by connecting impersonal data to real lives? A mainstream psychological theory such as social ranking theory (Gilbert, 1992) lends itself to connecting emotions such as shame to experiences of poverty and inequality as detailed by social epidemiologists (e.g. Wilkinson & Pickett, 2009). Perhaps bringing together social-psychological theory, epidemiological data and narrative accounts gives intellectual weight and emotional resonance to the debate on social issues?

So perhaps we have something to say and theories that can help inform the debate. Are
there risks to psychology getting involved? There are those who would argue that this is not an area that is important to us professionally or in our interests, and instead would stress the importance of individual work and the Improving Access to Psychological Therapy (IAPT) programme. In contrast, there are critics of IAPT for it offering individualistic solution to problems which have social causes (Pilgrim, 2008) and those who argue psychology’s individualistic models have already unhelpfully influenced discussions on society by obscuring context. This is a point made clearly by the Midlands Psychology Group, which has articulated an alternative framework for understanding distress (MPG, 2012). Can we professionally find a consensus to enable us to speak out on how society shapes individuals?

Boyle (2011) has argued that psychology has struggled to find its voice on social context, due to professional anxiety and insecurity – if this is the case, what is our moral duty to overcome our fear? Can we find a way to reason which is not driven by insecurity?

Addressing social issues is a democratic issue and one relevant for all citizens, so should the DCP speak publically on this topic? Is silence also a statement of sorts? Could we adopt ways of practising as psychologists that are more community oriented? Should our resources go into primary prevention and public mental health? Even if society is crucial, what about the people who are already suffering? How are they to be helped? I believe the profession needs to reflect upon these issues, and social justice should be central to our deliberations. The relationship between society and the individual are complex issues theoretically and in practice – they have given birth to a range of opinions across the centuries and continue to concern us through debate in the media and in our day-to-day lives. Does this complexity mean professionally we should be silent? My answer would be no – making sense of complexity should be a core to clinical psychology. I would suggest the DCP occasional papers and guidance should be populated with at least a few papers containing words such as ‘society’. Forming a professional position would require measured critical reflection on complex ethical issues – the values of honesty and modesty discussed in the last ethics column would appear crucial to such endeavours.

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