Alternatives to psychiatric diagnosis

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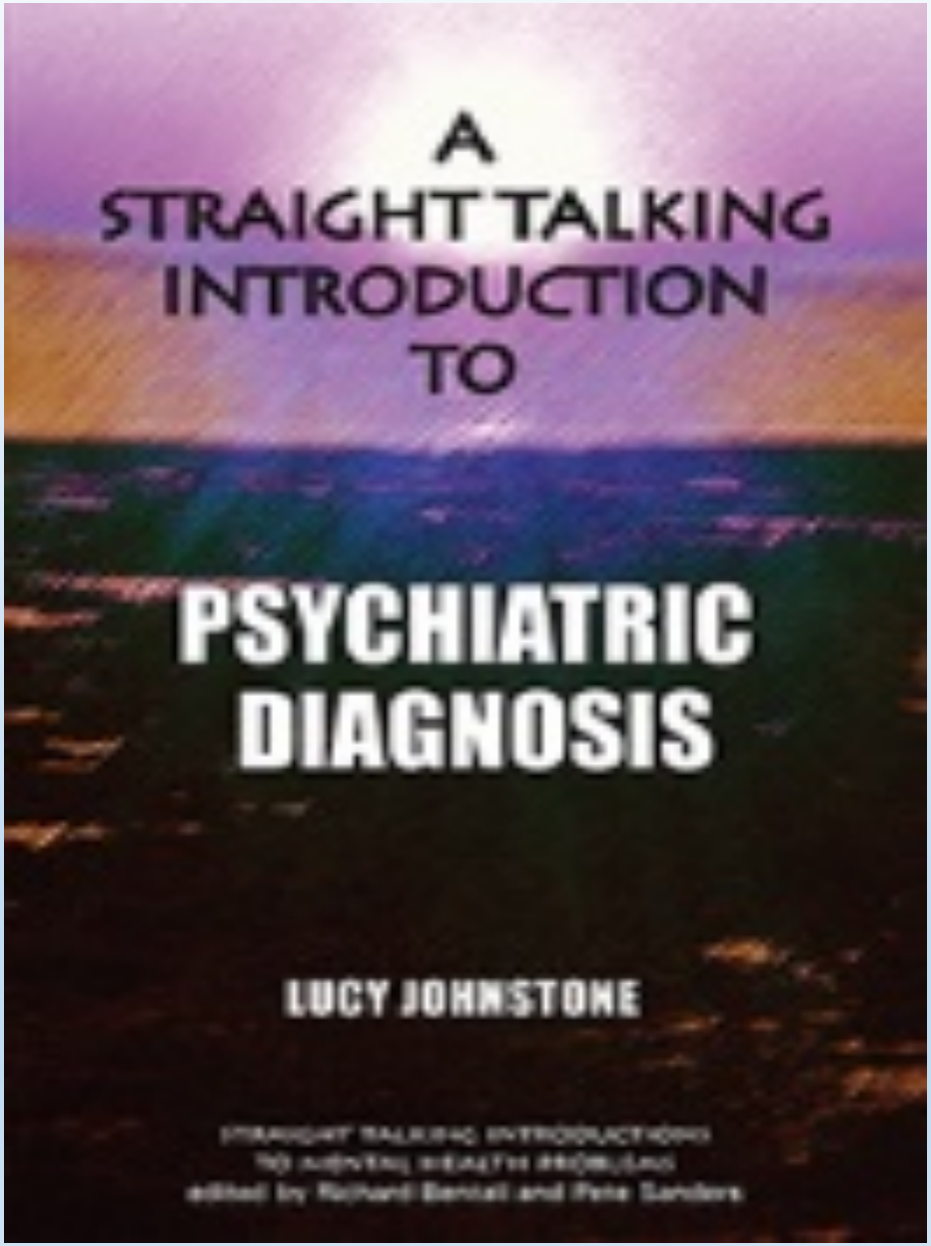
The questions:

- What are the problems with psychiatric diagnosis?
- What could we use instead?
- What choice do you want to make for yourself?

The question:

No one doubts that people who receive psychiatric services are in great distress. They may be tormented by hostile voices, feel suicidal, have terrifying mood swings and so on. But are they suffering from *medical illnesses which need diagnosing and treating by doctors?* Or do we need a completely different way of understanding their distress, which isn't based on diagnosis?


A
STRAIGHT TALKING
INTRODUCTION
TO
PSYCHIATRIC
DIAGNOSIS
LUCY JOHNSTONE

Aims of the book

- Summarise the arguments about diagnosis in an accessible way
- Describe some of the alternatives to diagnosis
- Give some suggestions and resources for people who want to explore non-diagnostic understandings

Two important messages:

Few people can afford to give up diagnosis entirely – it is needed for access to benefits, services etc. BUT *they may decide they do not wish to define themselves and their problems in this way.*

Acceptance of a diagnosis should be on the basis of informed choice, and not an imposed expert view

‘If the authors of the diagnostic manuals are admitting that psychiatric diagnoses are not supported by evidence, then no one should be forced to accept them. If many mental health workers are openly questioning diagnosis and saying we need a different and better system, then service users and carers should be allowed to do so too. This book is about choice. It is about giving people the information to make up their own minds, and exploring alternatives for those who wish to do so.’

The same message is given by Division of Clinical Psychology reports co-authored with service users:

‘**Understanding Bipolar Disorder**’

‘*Services should not insist that all service users see their problems as an “illness.”’*

http://shop.bps.org.uk/understanding-bipolar-disorder.html

‘**Understanding Psychosis**’

Free download from www.understandingpsychosis.net

‘*Hearing voices or feeling paranoid are common experiences which can often be a reaction to trauma, abuse or deprivation. Calling them symptoms of mental illness, psychosis or schizophrenia is only one way of thinking about them, with advantages and disadvantages*’ (p.6)

What is psychiatric diagnosis?

Diagnostic and Statistical Manual 5 (DSM 5)

(May 2013)

International Classification of Diseases 10 (ICD 10)

(version 11 is due in 2017)

About 400 different forms of 'mental disorder' in adults and children, plus criteria for psychiatrists to make the diagnosis

Roughly divided into 'psychotic' disorders (schizophrenia, bipolar, paranoia); 'neurotic' disorders (depression, anxiety, anorexia); 'personality disorders' (borderline personality disorder, psychopathy); organic disorders (dementia)

Why do we need diagnosis?

To indicate treatment, outcome, causation, aid communication, and give a basis for research

Even more importantly - a **reliable and valid** classification system is the foundation of any science. If we haven't got this – we have to ask whether psychiatry is a legitimate branch of medicine.

Without a valid classification system, psychiatry would become *'…..something very hard to justify or defend – a medical specialty that does not treat medical illnesses*' (Breggin 1993)

Diagnostic criteria for 'schizophrenia' (DSM 111)

Presence of characteristic psychotic symptoms in the active phase: either 1, 2, or 3 for at least one week:

Two of the following:

1. Delusions; prominent hallucinations; incoherence or marked loosening of associations; catatonic behaviour; flat or grossly inappropriate affect
2. Bizarre delusions, ie involving a phenomenon that the person's culture would regard as totally implausible, eg being controlled by a dead person
3. Prominent hallucinations of a voice…keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other

Prodromal or residual symptoms:

Marked social isolation or withdrawal

Marked impairment in role functioning as a wage-earner, student or home-maker

Markedly peculiar behavior (eg collecting garbage, talking to self in public, hoarding food)

Marked impairment in personal hygiene and grooming

Odd beliefs or magical thinking, influencing behavior and inconsistent with cultural norms, eg superstitiousness, belief in clairvoyance, telepathy, sixth sense

Unusual perceptual experiences eg sensing the presence of a force or person not actually present

Marked lack of initiative, interests or energy

So, on what kind of criteria is DSM based?

- No absolute cut-off between ‘well’ and ‘ill’
- Criteria are all essentially subjective, because…
- There are no medical tests for psychiatric problems

…and in fact there is no firm evidence for ‘biochemical imbalances’, faulty genes, or any other biological cause of ‘mental illness.’

Dr David Kupfer, chair of the DSM-5 committee: ‘*We've been telling patients for several decades that we are waiting for biomarkers. We're still waiting.’*

Circular arguments: without bodily signs to confirm the presence of these ‘illnesses’, diagnoses are not an explanation

Why does this person have ‘delusions’?

Because they have schizophrenia

How do you know they have schizophrenia?

Because they have ‘delusions’.

Cf:

Why does this person have headaches?

Because they have a brain tumour

How do you know they have a brain tumour?

Because it shows up on the Xray/blood test etc

Critiques of psychiatric diagnosis

- Psychiatric diagnoses are not what they claim to be….Psychiatrists are not identifying bodily illnesses. Instead, they are making **social, not medical**, judgements about disturbing or unacceptable ways of thinking, feeling and behaving.
- People who receive a psychiatric diagnosis may well be very distressed and in need of help, but this is not best understood as a medical problem. They are suffering from a complex mixture of social, emotional and relationship difficulties.
- Obviously, this has profound implications for the whole way psychiatry operates

…..and even more for the life of the person who is diagnosed

Even if psychiatric diagnosis is not a valid procedure, it has very serious consequences

‘I got a diagnosis of schizophrenia. With this I got the message that I was a passive victim of pathology. I wasn’t encouraged to do anything to actively help myself. Therapy meant drug therapy. It was hugely disempowering and undermining, exacerbating all my doubts about myself. And the impact was devastating because it just served to make the voices stronger and more aggressive because I became so frightened of them. What started off as experience became a symptom…… This all happened in a shockingly short space of time. I went into that hospital a troubled, confused, unhappy 18-year-old and I came out a schizophrenic. And I was a good one. I came to embody how psychosis should look and feel.’ Eleanor Longden

- Obscures personal meaning (this is an ‘illness’ which is nothing to do with my life experiences and their impact on me)
- Damages sense of identity (I am fundamentally different and flawed)
- Undermines agency (the belief that you can take action to change things)
- Takes away hope (the belief that you can recover)

Anti-stigma campaigns such as Time to Change are all based on the ‘illness like any other’ model – despite the well-established fact that this *increases not reduces stigma*

Diagnosis can have some advantages….

‘It gave me the comfort of explanation…. When I was told that I was depressed it gave me a framework of understanding and a first grip on what was happening.’

‘My label initially brought comfort and validation for my struggles.’

‘It’s (diagnosis of bipolar disorder) taking a bit of the guilt away for that I feel for all the things that have happened, that I’ve done…’

Mixed reactions:

‘For many years I accepted the medical model as a framework of understanding… But I gradually came to appreciate drawbacks …As a result, I began to actively explore frameworks that better met my needs.’

But it can turn *people with problems* into *patients with illnesses*

‘I walked into (the psychiatrist’s office) as Don and walked out a schizophrenic…I remember feeling afraid, demoralised, evil.’

‘The diagnosis becomes a burden…you are an outcast in society. It took me years to feel OK about myself again.’

‘The killing of hope….it almost feels like, well, your hands are tied, your cards laid and your fate set.’

‘I think schizophrenia will always make me a second class citizen….I am labelled for the rest of my life.’

Much evidence that ‘recovery’ is as much about overcoming the messages of the diagnosis and the effects of ‘treatment’ as it is about getting over an ‘illness.’

Leading members of the service user/survivor movement date their recovery from the moment they rejected their diagnoses

(Viv Lindow, Eleanor Longden, Ron Coleman, Rufus May, Jacqui Dillon, Rai Waddingham, Laura Delano, and many others.)

See website www.madinamerica.com for these and many other stories

The Recovery model

Recovery themes: finding a new sense of -

Connectedness (including support from others and feeling part of the community); hope and optimism about the future (including belief that recovery is possible); identity (including overcoming stigma); finding meaning in life (including the experience of 'mental illness'); and empowerment (including taking personal responsibility, focusing on strengths, and taking control of one's life) (Leamy et al 2011)

Was this the consequence of the 'illness' or of the diagnosis?

‘You have a medical illness with primarily biological causes’

vs

‘Your problems are a meaningful and understandable response to your life circumstances’

This is a mixed message about personal responsibility……

‘You have an illness which is not your fault BUT you retain responsibility for it and must make an effort to get better BUT you must do it our way because we are the experts in your illness.’

…….which leads to all the familiar contradictions of everyday psychiatric practice

Not compliant vs Too dependent

Won't accept they're ill vs Sick role behaviour

Too demanding of services vs Not engaging with services

These contradictions are inherent in the combining of two models with fundamentally incompatible core assumptions

Consequences for minority ethnic groups and non-Western cultures

DSM and ICD are inevitably based on the social norms of the white, Western culture in which they are produced.

Journalist Ethan Watters has documented the catastrophic results of exporting the DSM and all its implications to non-Western cultures *('Crazy like us*.')

Psychiatrists like Suman Fernando argue that this is simply another form of colonialism, less obvious but just as damaging as earlier forms (Fernando 2003)

The DSM-5 disaster…….

Dr Allen Frances' '10 most potentially harmful changes' include:

- Disruptive Mood Dysregulation disorder in children (more than 3 episodes in a week for over a year: replacement for childhood bipolar disorder?)
- Major Depressive Disorder – bereavement exclusion reduced to 2+ weeks (not 2 months)
- Binge eating disorder (excessive eating 12+ times in 3 months)
- Behavioural Addictions (eg in appendix: Internet addiction disorder; gaming disorder)??
- Somatic Symptom Disorder 'Disproportionate' concern about your health; devoting 'excessive time or energy' to health concerns

Dr Steven Hyman: DSM is *'totally wrong, an absolute scientific nightmare.'*

Dr Thomas Insel: *'Patients….. deserve better…..The weakness is its lack of validity.'*

'There is no reason to believe that DSM-5 is safe or scientifically sound…..The science simply isn't there now……A research dead end.' Professor Allen Frances, Chair of DSM IV Task Force

'There is no definition of a mental disorder. I mean, you just can't define it. It's bullshit' (Dr Allen Frances)
http://www.wired.com/magazine/2010/12/ff_dsmv/

Division of Clinical Psychology Position Statement on Classification 2013

> *'The DCP is of the view that it is timely and appropriate to affirm publically that the current classification system as outlined in DSM and ICD, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations and there is thus a need for a paradigm shift in classification in relation to these diagnoses, towards one which is no longer based on a "disease" model.'*

International and national coverage (eg The Observer 12.5.13 'Medicine's big new battleground')

Supporting statements from DECP, Critical Psychiatry Network, Hearing Voices Network England, Psychological Society of Ireland, Psychosis and Complex Mental Health Faculty, BACP, International Society for Ethical Psychology and Psychiatry

Not everyone was pleased!

‘Extremist posturing by the BPS’ (Allen Frances)

‘The groups… who are actually proud to identify themselves as “anti-psychiatry”…They are, to my mind, misguided and misleading idealogues and self-promoters who are spreading scientific anarchy’ (Leiberman, APA President, 20.5.13)

‘One UK psychologist used the DSM launch to say on twitter “All psychiatric diagnosis is wrong” and not be shouted down – instead being given the platform of the Today programme, our morning agenda setting current affairs show – to air her views’ (Wessely 6.6.13)

Questions/discussion about the points so far?

So…. How else can we understand these problems?

‘*There is now overwhelming evidence that people break down as result of a complex mixture of social and psychological circumstances – bereavement and loss, poverty and discrimination, trauma and abuse*’ (Johnstone 2013, The Observer)

Editorial in the British Journal of Psychiatry Feb 2012

‘After decades of ignoring the…..effects of negative events in childhood, researchers have recently established that a broad range of adverse childhood events are significant risk factors for most mental health problems, including psychosis….The implications of our having finally taken seriously the causal role of childhood adversity are profound’ (Read and Bentall 2012)

- Childhood trauma, sexual abuse, bullying and neglect is strongly linked to all psychiatric breakdown, including 'psychosis'
- The same is true of traumas in adult life – eg rape, domestic violence
- The more severe and frequent your experiences of trauma, the more likely you are to become 'psychotic'. People abused as children are 9.3 times more likely to develop psychosis; risk rises to 48 times for the severest abuse (Janssen et al, 2004); people who have experienced 3 kinds of abuse were 18 times more likely to be psychotic; 5 types of abuse = 193 times more likely (Shevlin et al, 2007.)
- The content of people's unusual experiences or 'delusions' is often closely related to actual experiences of abuse (Read et al, 2005)

The Hearing Voices Network

- Hearing voices is not a sign of 'mental illness
- Voice-hearing is a variation of human experience (like left-handedness)
- Many people in the general population hear voices and cope with them or even value them
- Psychiatric explanations leave people even more powerless
- Self-help strategies and HV support groups can help with distressing voices
- Hostile or distressing voices are frequently related to unprocessed histories of trauma, abuse and loss
- Understanding voices in the context of your life events, and working through the unresolved feelings, can transform them into allies

(Romme and Escher 1996)

Listening to people's stories – the radical alternative to psychiatric diagnosis.

Moral: *Instead of asking 'What's wrong with you?' we need to ask 'What's happened to you?'*

The alternative to diagnosing people: NOT diagnosing people! Work with ordinary-language descriptions of their difficulties

One way of doing this is via *psychological formulation* – a core skill for clinical psychologists and counselling psychologists. Many clinical psychologists do not use, or think in terms of, diagnosis at all.

Constructs, narrative approaches, etc

Formulation as an alternative to psychiatric diagnosis

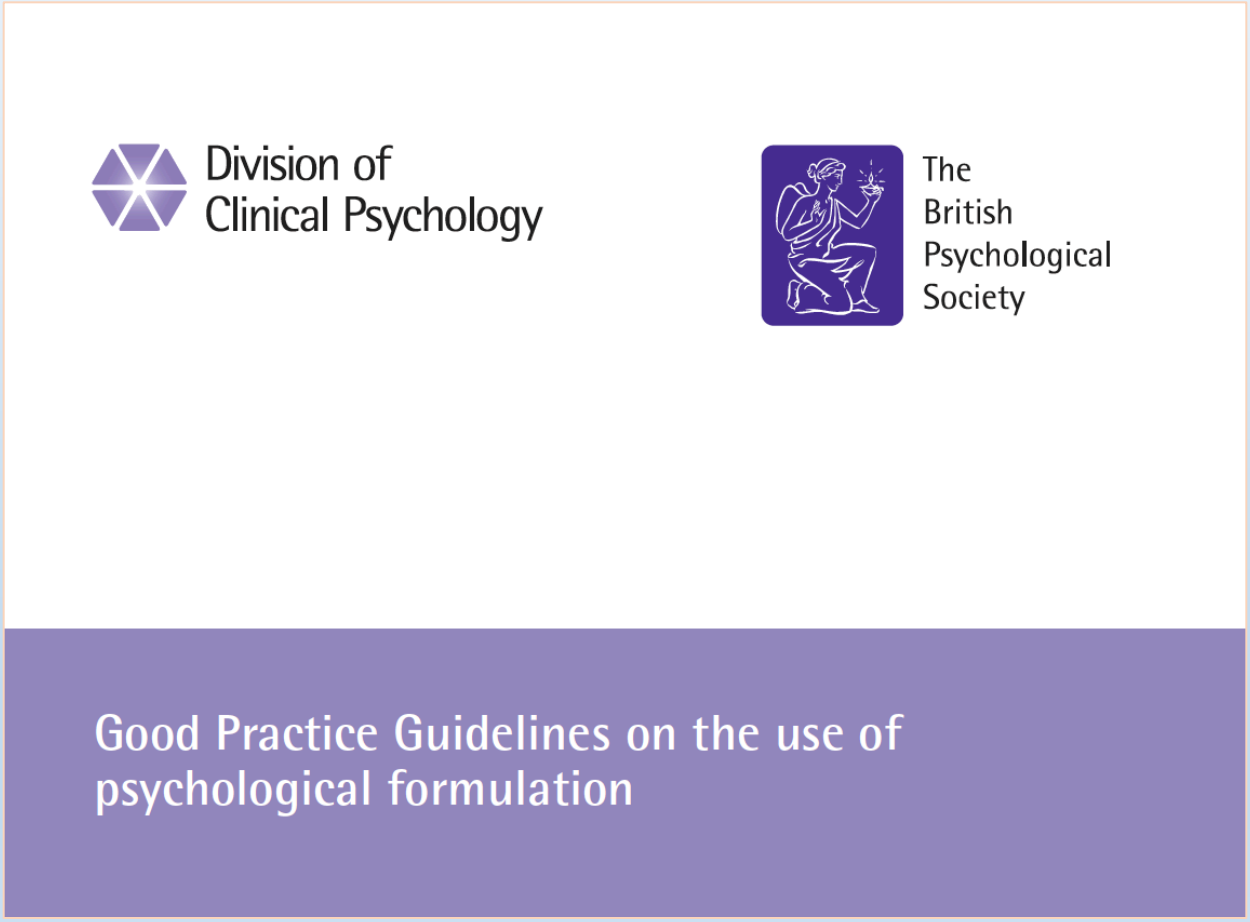
All formulations……..

- Draw on psychological theory and evidence to show how the service user may have developed their difficulties
- Are drawn up collaboratively with the service user
- Are open to revision and re-formulation
- Are used as the basis for a plan of intervention

A shared hypothesis or ‘best guess’ about what is going on

‘…..at some level it all makes sense…’ (Butler 1998)

Good practice guidelines on the use of psychological formulation DCP 2011



Partly because of your early experience of trauma, you were a quiet and hard-working child without a great deal of self-confidence. The transition to university was a shock to you. Unable to work out who you were or how you wanted to live your life, you felt very unhappy and confused. The appearance of your first voice seemed to be triggered by these worries, and many unresolved feelings came to the surface. Unfortunately, psychiatric treatment reinforced all your doubts and lack of confidence by giving you the message that you were defective, helpless and hopeless in the face of a serious mental illness. The more afraid you were of your voices, the more frightening they became. As you became further entangled in the identity of a mental patient, and felt increasingly powerless, the voices grew in power and dominance. Taunts and rejection from other people increased your sense of alienation and rejection. The dominant voice took over, and you felt completely in his control.

We have talked about how you need to start believing in yourself and taking some control back from the voice, and questioning other people's definition of you as a hopeless schizophrenic. We have begun to understand that the voice represents the insecure and rejected parts of yourself, and calls attention to unresolved issues from the past. There may be things that you can learn from the voice which will help you on your path to recovery. You are an intelligent, determined and resourceful person, and these strengths will help you to find a way forward.

- What differences do you notice between the diagnosis and the formulation?
- How might it be experienced by the individual?
- What ways forward are suggested by the formulation?
- If you have a formulation….does a diagnosis add anything? Do you need a diagnosis as well?

Formulation is a different type of explanation from diagnosis

'……a process of ongoing collaborative sense-making' (Harper and Moss, 2003)

'….a way of summarising meanings, and of negotiating for shared ways of understanding and communicating about them' (Butler, 1998)

'It was the first time that I had been given the chance to see myself as a person with a life story, not as a genetically-determined schizophrenic with aberrant brain chemicals and biological flaws and deficiencies that were beyond my power to heal….. Pat Bracken was so much more humane than that. And he didn't talk about auditory hallucinations, he talked about hearing voices and unusual beliefs rather than delusions, anxiety rather than paranoia. He didn't use this terrible mechanistic, clinical language, he just couched it in normal language and normal experience.'

Eleanor Longden – now an internationally-known speaker, TED finalist, trainer and researcher

http://www.ted.com/talks/eleanor_longden_the_voices_in_my_head.html

The overall message of a psychological formulation is:

'*You are experiencing a normal reaction to abnormal circumstances'*

'Anyone else who had been through the same events might well have ended up reacting in the same way'

'Symptoms' are in fact survival strategies – essential at the time but they have outlived their usefulness

A simple but radical and empowering message in the context of the dominance of the biomedical model of emotional distress

'Formulation in psychology and psychotherapy: making sense of people's problems' Johnstone and Dallos, 2013

Constructs - a version of a formulation for voice-hearing

An answer to the question: 'How can we make sense of your voices?'

- As a historical relationship (eg divorce, bereavement)
- As a psychodynamic relationship (eg voices as a defence against unbearable emotions and memories)
- As a metaphorical relationship (ie symbolically representing the person's difficulties)

(Romme and Escher 2000 'Making sense of voices')

All these understandings need exploration with the voice-hearer and weaving together into a meaningful explanation

‘There is no such thing as a good or a bad construct… a construct should never be forced on someone’ (Romme and Escher 2000)

Construct: ‘The voices started when she was in puberty and having a lot of problems with her father. She was not allowed to be herself at a time when she was searching for her own identity. She felt powerless. Her father made her angry because he wanted to run her life for her, but she was not allowed to express that anger towards him. Erichem did the same thing – made her angry – and in this way the voice became a metaphor for her father. When the voice was present, she opposed him by swearing back at him, but this made the voice more negative. This is exactly what happened with her father. She could not discuss with either her father or the voices what they were saying to her, but could only become afraid or hostile. There were strong similarities between the voices’ comments and criticisms and what her father used to say.’

Putting together your own story…….perhaps with help from a friend, partner or therapist?

‘Whenever we talk about ourselves we tell stories. Without these stories, our experiences would sit – unconnected – like a thousand tiny beads. Telling our story helps us to weave connections between these beads, linking them together with different threads to create a tapestry full of meaning. This is a fluid and continually evolving process. Each new experience, interaction or connection reveals new aspects of the picture we are continually creating. It shifts and changes as we, ourselves, shift and change.

Reflecting our experience of the world, this process can be terrifying and confusing as well as beautiful and rewarding. In psychiatry, something profound happens to these stories. It's as if someone takes your tapestry, labels it as defective and gives you the pattern you need to rectify your mistakes. Unquestioningly, you unpick your tapestry and – instead – weave the beads together to form a picture of symptoms, diagnosis, illness, genetic vulnerabilities and pathological responses to stress. With each stitch, those around you nod and praise your keen insight. After a while you forget that you ever had a story of your own. In this way, a 'schizophrenic' is born …

It was at university that my inner world first began to seep out through the cracks and show itself to others … It was at this point that I was given an alternative – a new pattern to help impose some order on the chaos. It was at this point that I became a 'schizophrenic'. In the hospital I met many kind mental health professionals who gently reassured me that I was psychotic – that my complex and frightening beliefs about my experiences were 'primary delusions' and that the alien and the bugs were simply 'hallucinations', products of my unbalanced brain chemistry and my intolerance to stress. On adopting this new perspective I felt relief – the medical lexicon stripped my experiences of their power and removed any need to further explore their meaning.… Of all the beliefs that I have had about my experiences, the belief that I was 'schizophrenic' was the most damaging …

The peer support group I attended gave me something truly precious – a safe space to begin to find my own way of describing, and making sense of, my experiences. After years of parroting the biomedical picture I'd been given ('Hi, my name is Rachel and I'm a schizophrenic'), I met people who wanted to know more. Slowly and tentatively, I began to unpick the medical tapestry and began to weave my own story once more.'

Rai Waddingham Blog at www.madinamerica.com

Website www.behindthelabel.co.uk

‘In the early 1980s I was diagnosed as schizophrenic….In 1993 I gave up being schizophrenic and decided to be Ron Coleman. Giving up being a schizophrenic is not an easy thing to do,for it means taking back responsibility for yourself, it means that you can no longer blame your illness for your actions…but more important, it means that you stop being a victim of your experience and start being the owner of your experience.’

Ron Coleman, 1999

What happens next….? Debate in British Journal of Psychiatry

'Some observers have questioned whether the psychiatrist is an endangered species…Urgent action is required… to ensure the future of psychiatry as a profession' (Oyebode and Humphrys 2011)

Critical Psychiatry Network: '*The DSM is incapable of capturing the full range of experiences of distress in the way that narrative formulation can'* (2.5.13)

Team formulation - a powerful way of changing cultures

In which a team or group of professionals develop a shared psychobiosocial formulation about a service user

1.Regular meeting for most or all team members, at which a formulation is co-constructed

2.Parallel process of formulating with the service user when appropriate, which informs and feeds into the team formulation

Ideally…….

3.Formulation integrated into every part of the service, from initial assessment onwards

'Using formulation in teams' chapter in Johnstone and Dallos (2013

Team formulation in Cwm Taf Health Board

Regular weekly meetings (minimum an hour) at which attendance from as many team members as possible is encouraged

Clients can be ‘booked in’ for discussion and staff from other teams/agencies invited as appropriate

Key worker prepares brief summary of personal and psychiatric history in advance

Simple format:

-What is the current question or ‘stuck point’?

-Is the background correct/complete?

-Develop a shared formulation

-Draw out implications for intervention

-Facilitator writes it up and circulates for agreement

-Added to the records

-Review as necessary in future meetings

Essential features of a team formulation

- Formulates the ‘symptoms’ and psychiatric diagnoses
- Transference and counter-transference between service user and team
- Attachment-based perspective on the way the service user interacts with the psychiatric service as a whole
- Psychological framing of medical interventions (eg medication)
- Awareness of social factors, including ‘mental patient’ role
- Possible role of trauma/abuse
- Possible re-traumatising role of services
- Attention to process factors within the meeting

100% of the participants felt that the meetings had helped to develop a shared team understanding of a client's problems, strengths and difficulties; draw on the knowledge and skills from different professional backgrounds; generate new ideas about working with the client; develop an intervention plan; and improve risk management.

(Hollingworth and Johnstone, 2014)

Regular team formulation meetings now running in:

- All CMHTS
- Both AO teams
- Rehab service
- Inpatient wards

Local social care teams have also requested training and are using the model

Cardiff psychology services have borrowed the model and are introducing it in their health board

Positive signs….

A non-diagnostic, trauma-informed training and intervention package for all staff (Emotional Focused Formulation Approach) is integrated into secondary Adult Mental Health in Southampton (Isabel Clarke's work.)

Sussex Partnership Trust has introduced formulation into all stages of the care pathway from assessment onwards in its Adult and Older Adult service

Older Adult service in Tees Esk and Wear which uses individual and team formulation in 10 community teams and 4 wards: Organic & functional; inpatient & community. All 400 staff have mandatory training in formulation. It is integrated into standard processes and records.

‘The knowledge of horrible events periodically intrudes into public awareness but is rarely retained for long….Clinicians know the privileged moment of insight when repressed ideas, feelings, and memories surface into consciousness….Victims who have been silenced begin to reveal their secrets…. Survivors challenge us to reconnect fragments, to reconstruct history, to make meaning of their present symptoms in the light of past events.’

Judith Herman, ‘Trauma and recovery’

NICE guidelines on ‘Schizophrenia’ 2014

‘Recently, emphasis has also been placed on the value of multi-disciplinary formulation and reflective practice, particularly where psychologists and mental health professionals operate within teams…’

‘…write a care plan in collaboration with the service user as soon as possible following assessment, based on a psychiatric and psychological formulation…’

‘The toxicity of the label of “schizophrenia” has led to calls to abandon the concept altogether…. This has led to some professionals and user/carer groups….instead preferring to emphasise a narrative or psychological formulation of an individual’s experiences’

On the other hand….

Reactions to ‘Understanding psychosis’:

‘…exploits, disrespects, silences and marginalises service users.. *Understanding Psychosis* should be seen as a cruel hoax perpetrated against more typical severely disturbed mental health service users, their family, and policymakers’

‘And while the psychologists lobby for a greater piece of the treatment pie….slanting to their own "narrow professional self-interests" ….the suffering of those with the most serious of mental health problems and issues -- real illnesses -- continues.’

‘It promotes a main message that people need not accept medical models of psychosis and might do just as well to “find meaning” in their symptoms, embrace “psychological therapies,” and opt out of taking medication. In other words, if you don’t want to think of yourself as mentally ill, then don’t. If you don’t want to accept recommendations for medications, then don’t.

To a psychiatrist who treats people with serious mental illness, this sounds like dangerous advice. One of the biggest challenges of working with patients with psychotic disorders is getting them to accept their diagnosis and to engage in treatment, whether pharmacotherapy or psychotherapy. The very definition of delusional thinking, one of the hallmarks of psychosis, includes the belief that there’s nothing wrong and that one doesn’t need treatment. This lack of insight is one of the most common barriers to recovery.’

Listening to people's stories is a radical act which

RESTORES MEANING

RESTORES AGENCY

RESTORES HOPE

…..for service users and staff

…..puts back what psychiatry takes out

Resources

Johnstone, L (2000) (2nd edn) Users and abusers of psychiatry: a critical look at psychiatric practice. Routledge

'Medicine's big new battle ground: does mental illness really exist?' The Observer 12.5.13 http://www.theguardian.com/society/2013/may/12/medicine-dsm5-row-does-mental-illness-exist

Eleanor Longden, formerly diagnosed with schizophrenia and now a researcher and campaigner, gives an inspiring TED talk at http://www.ted.com/talks/eleanor_longden_the_voices_in_my_head.html

An equally inspiring talk by Jacqui Dillon, chair of the Hearing Voices Network in England http://www.youtube.com/watch?v=JHzHliy5yeQ

Talk by two psychologists from the Salomons course on 'Is life a disease?' http://www.youtube.com/watch?v=XQxORhtHiow

Blog on www.madinamerica.com/author/ljohnstone by Lucy Johnstone critiquing diagnosis and promoting formulation as an alternative, plus many other articles on the www.madinamerica.com site

Johnstone, L Diagnosis and formulation (2013) In (eds) J Cromby, D Harper and P Reavey

U*nderstanding mental health and distress: Beyond abnormal psychology* Palgrave Macmillan