Correspondence

Beyond dualism and defamation: utility and action

A more interesting question than 'where does the truth lie?' is to ask what are the implications for persons and society of the respective positions of Szasz[1] and Shorter.[2] Even respected nosologists, explicitly acknowledged in the American Psychiatric Association's Research Agenda for DSM-5, have abandoned the quest of establishing nosological validity (on the basis of the failure of even modified Feighner criteria) for most psychiatric 'disorders', but instead are asking questions about the utility of different diagnostic criteria.[3] Therefore, if Szasz is right and mental illness is a metaphor, the Shorter camp might productively ask 'is it a useful metaphor?' instead of reverting to a wholly outdated mind–body dualism.

Functional brain imaging reflects lived mental states, and particular brain areas may 'light up' in response to a person's interaction with others and their environment, without necessarily implying neurological causality. Even structural brain changes can in fact imply interpersonal and environmental causality, as the neuroimaging exploring the impact of childhood maltreatment makes clear.[4] And 'difference' of course does not automatically imply 'disease', as the neurodiversity movement has so eloquently argued.[5]

Individual mental phenomena can be simultaneously described at multiple theoretical levels – from neural networks and psychological descriptions through to narrative, meaning and conscious experience – with bidirectional influence between levels. How neuropsychological processes are recursively embedded within wider social processes is more complex still, although social looping theory is a useful starting point here.[6] The ability, however, to hold multiple levels of description in mind often breaks down when meaning is translated into action. The belief that the 'voices in my head' are due to a progressive neurological disease as opposed to a disgruntled ancestor or spirit has almost irreconcilable consequences for action. The first signifies a need for medical treatment, presumably medication, the second perhaps a need for dialogue or appeasement with the ancestor/spirit (or, within our contemporary psychologised cultural milieu, perhaps dialogue and integration with this voice/'split-off self part'). Members of the Hearing Voices Network would hold to whatever appears useful.[7] New meanings may themselves influence psychological and associated neurological processes reinforced by social looping.[6] Medication can only be reconciled with the ancestor/spirit metaphor as 'something that might take the edge of my distress' while engaging with this process of restitution, although not all voice-hearers find this acceptable or necessary.[7]

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

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

1 Szasz T. The myth of mental illness: 50 years later. *Psychiatrist* 2011; **35**: 179–82.

2 Shorter E. Still tilting at windmills. Commentary on . . . The myth of mental illness. *Psychiatrist* 2011; **35**: 183–4.

3 Kupfer DJ, First MB, Regier DA (eds). *A Research Agenda for DSM-V*. American Psychiatric Association, 2002.

4 Teicher MH, Andersen SL, Polcari A, Anderson CM, Navalta CP, Kim DM. The neurobiological consequences of early stress and childhood maltreatment. *Neurosci Biobehav Rev* 2003; **27**: 33–44.

5 Fenton A, Krahn T. Autism, neurodiversity and equality beyond the 'normal'. *J Ethics Ment Health* 2009; **2**: 2.

6 Seligman R, Kirmayer LJ. Dissociative experience and cultural neuroscience: narrative, metaphor and mechanism. *Cult Med Psychiatry* 2008; **32**: 31–64.

7 Romme M, Escher S. *Accepting Voices*. Mind Publications, 1993.

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Removal of experts immunity

The papers by Thompson[1] and Rix[2] provide useful information for anyone thinking of entering the field of medico-legal work. Anyone in this position will also want to be aware that earlier on this year, in *Jones v. Kaney*,[3] the Supreme Court decided by a majority of 5 to 2 to remove the immunity that expert witnesses have previously enjoyed. It is too early to say how this is going to affect such work.

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

Medico-legal work is interesting and challenging, but it does require sound foundations.

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

2 Rix KJB. Medico-legal work of psychiatrists: direction, not drift. Commentary on . . . 'You are instructed to prepare a report'. *Psychiatrist* 2011; **35**: 272–4.

3 *Jones v. Kaney* [2011] UKSC 13.

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The psychiatrist as expert witness

Thompson[1] and Rix[2] make particularly interesting statements regarding continuing professional education in the area of providing expert reports. I generally agree with the requirements listed by Thompson, with the exception of expecting the psychiatrist to have had specific training in being an expert witness. It seems to me that, although advice about conduct in court is prudent, the requirement of specific training is redundant. The competence and expertise of the witness should rapidly become apparent to the court during the process of giving evidence and being cross-examined.

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

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

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

2 Rix KJB. Medico-legal work of psychiatrists: direction, not drift. Commentary on . . . 'You are instructed to prepare a report'. *Psychiatrist* 2011; **35**: 272–4.

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Psychiatric reports: a must for all psychiatrists

Thompson's article[1] about preparing psychiatric reports for courts contains some useful advice, but we were left wondering why she had taken the time to write it, given that she suggests such reticence in taking on this work.

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

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

Training then becomes crucial, and Rix[3] has – much more encouragingly – discussed some of the ways in which it can be acquired. However, he does not address some of the associated matters that Thompson rightly raises. In particular, matters of probity relating to payment for work done and the interface between providing fee-paying services (category 2 work, as it was) and one's contractual NHS duties are important, and perhaps are not given the explicit attention in training and supervision that they deserve.

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

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

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

Declaration interest

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

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