Association for Humanistic Psychology in Britain
AHP new vistas MAGAZINE
AHPB Magazine for *Self & Society* | **No. 2 - Winter 2018/19**

The AHP Magazine Interview – II

Towards a More 'Humanistic' Psychiatry?

Professor **Sami Timimi** in conversation with **Richard House**

Richard House [RH]: I've long been an admirer of your work, Sami, specifically around 'critical psychiatry' (if I can use that term) and children's mental health, and so it's a great honour for me to interview you for the AHP magazine. Before we get into discussing the core concerns of your recent and current work, could you start us off with something about your own vocational journey into psychiatry – for example, your educational background, at what point you knew that psychiatry was the path you wanted to pursue, and the motivations and inspirations that drew you to this field.

Sami Timimi [ST]: Thanks Richard for inviting me to do this. You have been tireless in your efforts to improve well-being for children and young people, so the privilege is mine.

I came into Medicine initially almost by accident, as a last-minute choice, when I came to choosing what to do at university. By then I was more interested in music than studying, and was playing in a band; but sense prevailed, and I got accepted to study Medicine at Dundee University. I first came across Psychiatry in my 4th year as a student when we had to do a placement, which included interviewing and writing up several patients' accounts, and 'analysing' them from a psychiatric perspective. I remember the second patient I interviewed was a lady in her 50s who had been a long-term patient in the main psychiatric hospital and who had a diagnosis of 'schizophrenia'. Her story made quite an impression on me. She had many delusions (e.g. of having magical powers and virgin births of hidden babies), but somehow her account made some kind of sense to me (I had read in the notes about her husband dying suddenly in his 30s and her losing their first baby shortly afterwards, with her 'psychosis' emerging after that).

Intrigued, I wanted to go beyond just the standard psychiatric formulation (recounting signs and symptoms, making a differential diagnosis list, arguing for a particular diagnosis and concocting a management/treatment plan). So I went to the library to find something that would help with a more 'meaningful' formulation and duly came across R. D. Laing's book *The Divided Self*. I was gripped by this, read it in a couple of sittings and then did my write-up with plenty of references to this book. The marked essay came back as 'failed', and I was left in no doubt that Laing was not considered a psychiatrist who knows what they're talking about! It was my first taste of what I came to love and hate about psychiatry. As a student I had no idea that there was such a thing as 'anti-psychiatry': after all, you don't find this in any other branch of medicine (although there are lots of debates and uncertainties, they don't reach that level); and why would such a book be in the university medical school library if Laing wasn't considered to be a 'proper' psychiatrist?

What I came to love is that this is a field that is the meeting-point of experience and a whole variety of academic enterprises (from biology to psychology, from anthropology to politics etc.), all of which have something to do with engaging with the question/nature of the human condition. Thus, it's an area of practice that is intimate, creative, emotional, challenging and so on, as it has to engage with the 'experience' of suffering. What I came to hate is that, perhaps threatened by loss of power or a lack of prestige amongst other doctors, some psychiatrists and psychiatric institutions can become closed to thinking and imagining outside very narrow parameters, and thus retreat into the fantasy that distress/difference can be classified and treated in a simplistic way that 'looks' like what other more technically developed branches of medicine do. This has made psychiatry vulnerable to being co-opted by the pharmaceutical industry into the mass selling of consumerist snake oils (like anti-depressants) that are, by my reading of the evidence, ultimately doing more harm than good.

Anyway, to get back to my journey into psychiatry, the next bit was that after my psychiatry placement, I came to realise that when I was in my various other placements, I was more interested in the stories people were telling me about their life and the impact of their physical condition on it and the people around them, than I was in the specific condition that brought them to hospital. I was also getting feedback that I was a good listener, so that by the time I left medical school I knew that once I'd completed the mandatory 'house officer' year, I wanted to go into psychiatry – and that's exactly what I did.

RH: What a wonderful story about how you discovered Ronnie Laing's work, Sami! (I also discovered Laing at university, but from more of a critical social science vantage-point). And your marked essay quoting Laing's work *of course* came back as a 'fail'! – and now, folk like us all know why. For this is about paradigms and world-views – and Thomas Kukn's work shows all too clearly how an old paradigm will fight to the death to maintain its hegemonic power and its way of seeing the world (I remember stories of how, whenever Laing's name was mentioned at psychiatry conferences, hissing and even booing would ensue from the assembled ranks – quite extraordinary).

There's so much I want to pick up on in your first reply, Sami – but can I start by asking you about the current state of Psychiatry, and whether the vocal existence of anti-, critical, and post-psychiatry has made any impression upon mainstream psychiatry as practised and theorized today; or is the old paradigm still utterly insulated from these many and cogent critiques, that you and others have been making so eloquently and convincingly for many years?

ST: It's really quite frustrating. On a personal level the psychiatrists I meet and work alongside are in the main thoughtful and compassionate, and are trying their best for their patients. System wise, however, the institutions of psychiatry, as I mentioned earlier, have failed to challenge the 'dumbing down' of the intricacies of the human condition and its troubles into simplistic (what I call 'MacDonaldized') constructs that are amenable to being placed into discrete categories with particular corresponding technical interventions.

The evidence that this way of operating isn't working is all around us. Studies on outcomes from those who attend real-world mental health services find, in countries with the most developed services, that as few as 15–25 per cent are 'recovering'. Most experience either no lasting improvement, or else deteriorate. What has happened to 'cover up' this disastrous state of affairs is that we've created an idea that the conditions we deal with are 'chronic'. This provides a framework for accepting as unproblematic, the expanding numbers of people categorized as mentally ill, who don't seem to get better, or who keep relapsing despite our treatments, without feeling that it is, at least in part, the fault of our concepts or treatments themselves. Thus, I have colleague psychiatrists in adult services with case-loads of 600 or 700 patients. They are overwhelmed, and all they can do are 20-minute medication reviews once every six months or a year for patients who never get discharged.

I often wonder what might happen if we became more curious about differences in practice and outcome (but I understand this probably feels too threatening to look at). For example, I hold a case-load of around 50–60, see young people and families for at least one-hour sessions, and for some, that can at times be once a week; and most of the people I see get better and are discharged – and so I am free to do therapeutic work with more people. Very few are on medication, and with those who are, it's often because I inherited them from another clinician who had initiated the medication.

I'm aware that this picture is not one that most my colleagues in Child and Adolescent Psychiatry would recognize. Like their colleagues in adult psychiatry, they also often end up accumulating cases, for most of whom they will end up prescribing medication, as sadly this has increasingly come to be viewed as the role of the psychiatrist. Caught in a system that traps you like that, I think it's very hard for change to come from 'within' the profession. I suspect that psychiatry ultimately will be 'forced' to change by pressures from outside, particularly if the focus is shifted to the poor record of outcomes at the cost of high levels of harm that comes from more 'medical' interventions.

The problem for critics like myself and critical organizations (like the Critical Psychiatry Network – CPN) is at least twofold. First, we cannot match the power and influence that come from resource-rich bodies like the pharmaceutical industry – hence we have only been able to make marginal differences. This is mostly through other like-minded 'critics' having a body like the CPN to help with the support, friendship and the academic credibility needed to enable someone to practise beyond the narrow confines of the institutions we operate in work.

Secondly, as individuals, those of us who go against what are considered as the 'standard' institutional expectations of psychiatrists and the standard NHS (for example) processes are at risk from employers persecuting their practice. So I myself have previously had to robustly defend myself from accusations of incompetence by colleagues with more power than me, and I know of other consultants who have, for example, been referred to the Royal College of Psychiatrists for 'retraining'. Nonetheless, we have survived, we keep going, and I believe there will come a moment when there is enough of a 'critical mass' for this particular house of cards to come toppling down. I just don't know how close to that moment we might be.

RH: Sami, thanks for such an enlightening insight into the struggles that (dare I use the term) 'humanistic psychiatrists' have in that system. I had no idea that you sometimes have to withstand and survive direct attacks on your work of the kind you describe – that's just appalling. I'm thinking... – there's an article here! (if you ever felt like writing all this up... – but there again, if you were to go overtly into print with something like this in an

academic journal, perhaps that would only expose you to yet more attacks).

I'm again thinking of Thomas Kuhn's seminal work on scientific revolutions (Kuhn, 1962), and the way in which those who are professionally and/or ideologically aligned with a prevailing paradigm, but which in evolutionary terms is on the way out, will go to almost any lengths to defend their worldview (in Galileo's day, with appalling tortures: thankfully, things aren't quite that bad today – except that who knows, in these highly regressive days in this new Age of Trump...).

But I guess this raises a fundamental question for all radicals and critical thinkers labouring 'in and against' a paradigm that they know to be both wrong and damaging: viz. what strategies *are* open to professionals who find themselves 'in the tent p***ing out' (if I may be so vulgar), and perhaps subjected to the massive conservative forces that are absolutely determined to defend the old moribund worldview in every conceivable way? I'll just leave that one hanging there – and of course do pick up and run with it, if you'd like to.

But I also wanted to shift the conversation to your work with children and so-called 'ADHD' (*aka* Attention Deficit Hyperactivity Disorder), Sami (and I've carefully chosen the adjective 'so-called'!). I just love the various books and papers you've written in this field (e.g. Cohen and Timimi, 2008; Runswick-Cole et al., 2016; Timimi, 2002, 2005, 2007, 2009; Timimi & Leo, 2009; Timimi et al., 2010). Could you say something, first, about the 'ADHD' diagnostic category, and whether it serves to obscure rather than enable children with 'behavioural disturbances' (if I may use that term) to get the help they really need?

ST: Your reflection on the relevance of Thomas Kuhn's work on the nature of scientific revolutions is insightful. I think the idea of a 'paradigm shift' is often used too lightly to refer to changes that are anything but paradigmatic; but a genuine 'paradigm shift' is what we now need in mental health/psychiatry. A couple of 'critical psychiatry' colleagues (Patrick Bracken and Phillip Thomas – Thomas et al., 2012) and I wrote a paper a few years back, invoking Thomas Kuhn and arguing that the scientific evidence tells us that we need to shift away from a 'technical' model (for example, that of using diagnostic matched treatment models) and towards a relational/contextual model for understanding and intervening. This then led to gathering together a group of 29 British psychiatrists to write a 'position' paper on this theme which was published as an editorial by the *British Journal of Psychiatry* in December 2012 (Bracken et al., 2012). The paper was a riposte to earlier editorials by other groups arguing that (like American psychiatry) British psychiatry should be moving toward a clearer adherence to a 'professionalized' medical model, where psycho-social aspects are left to others, and psychiatrists polish up their 'clinical neurology'-style skills.

Our *British Journal of Psychiatry* paper has now been translated and re-published in a number of journals (including in Italy, Spain and South America). So although we are a long way from influencing the mainstream, there has been some interest and acceptance that more than one view is present and needs to be heard. In my more optimistic moments I think we are getting closer to that moment when enough of a critical mass is present to create that shift. After all, the evidence (including the absence of *any* evidence that the biomedical model has brought anything useful to mental health care) can't be suppressed indefinitely.

Returning to your second question; my foray into the arena of 'ADHD' started during my training years in child psychiatry in the mid-1990s, when we in the UK were just beginning to get interested in the concept. During one of my placements, my supervising consultant said he wanted to do some research into links between learning difficulties and ADHD, and asked me if I would like to do a literature review to start this off. I was keen to do this, so went off and started reviewing literature, but I couldn't get to the bottom of what ADHD actually is. The more I looked, the more confused I became. Surely there is more to such a diagnosis than just the presence of behaviours such as 'hyperactivity' and 'inattention' (i.e. ADHD is just those words – Attention Deficit, Hyperactivity). I found this frustrating, as I could see the circularity of defining something through rather rudimentary de-contextualized descriptions of behaviour, and then treating this description as if it is a newly discovered 'thing' that can c*ause* these behaviours.

To be honest I was astonished (and still am) at the superficiality and plain stupidity of this. I couldn't believe that people, who should know better, were writing papers and books treating such an abstract description as if it were a concrete, discrete, knowable, natural occurring entity/disease state. Thus began a long journey into the territory of the so-called scientific literature (which isn't very scientific at all), and my attempts to not only 'deconstruct' the concept, but to also understand why we are so taken in by such fictions, and what this results in when we are.

Where this has led me since is to understanding that in psychiatry there is no such thing as 'diagnosis'. Diagnosis in medicine refers to the process of understanding how a person's symptoms relate to an underlying disease process. Diagnosis is a technical process in which a medical practitioner identifies a possible cause or causes of a patient's complaints. Making the correct diagnosis in medicine is essential for choosing the correct treatment. In psychiatry we have a number of systems for the classification of people's complaints, but we don't have diagnoses. The classifications we use are descriptive (they describe the patient's problems), but not diagnostic (they tell us nothing about the possible causes of those problems) and therefore do not aid decision-making for treatment – and may lead to worse outcomes if the classifications are used as if they are diagnostic (which is not to say that the technical/diagnostic model used in the rest of medicine is not also problematic

in a number of ways, but at least it rests on solid scientific foundations).

In psychiatry, therefore, what is referred to as a 'diagnosis' will only describe but cannot explain. What happens if we do try to use a psychiatric diagnosis to explain really illustrates the flaw of considering psychiatric diagnoses as explanatory. If, for example, I were to ask why a particular child can't concentrate, is hyperactive and shows impulsivity, and I were to answer that it's because they have ADHD, then a legitimate question to ask is, 'How do you know it's because they have ADHD?'. The only answer I can give is that I know it's ADHD because the child is presenting with hyperactivity, impulsivity and poor attention. It's a bit like saying my headache is caused by a pain in the head.

The thing is, we've been cultured by influential (and, to my mind, corrupt) sections of the mental health establishment (psychiatry, psychology and some psychotherapies etc.) into making precisely this error; i.e. treating concepts like ADHD as if they have explanatory powers. This leads to reification – i.e. treating a concept that emerges out of the diagnoser's imagination as if it represents a real thing that exists in concrete form in the world out there beyond the diagnoser's thoughts. This not only atomizes children into individual flawed units; it also cultures everyone around them into thinking this way.

Furthermore, the focus is now on certain behaviours that come to be viewed as 'symptoms' to be got rid of (as opposed to the many other possibilities, such as a form of communication, a healthy curiosity, a need for more stimulation, a skill that is just developing etc.), and other aspects (emotional well-being, family relationships, strengths, resilience, lifestyle etc.) all become of lesser importance in therapeutic endeavours. I have come to feel that diagnoses like ADHD reflect an ambivalence that neoliberal Western culture has toward children that is often manifest in the tendency to problematize 'childish' behaviours and then 'medicalize' them, sparing all concerned from the more difficult task of accepting, understanding and supporting the imperfect and often contradictory ways children develop and seek/find emotional security.

RH: Yes, Sami – to my mind it's *exactly* like saying 'my headache is caused by a pain in the head'! And what a wonderful essay title for Psychiatry trainees and critical psychology students – 'In psychiatry there is no such thing as 'diagnosis'. Discuss'!... I love it. I think that Michel Foucault's notion of 'regimes of truth' is a very useful concept for trying to make sense of all this, and the way in which culture-bound ideologies have been so successful at dressing up in the garb of technocratic science that it becomes extremely difficult for most of us to begin to think outside of those pernicious discourses. Bring on 'The Emperor's New Clothes' fairy tale, perhaps! (e.g. Kirsch, 2009).

You've given such a wonderful answer to my question here, Sami, I hardly know where to start – and I find what you've said so affirming of all I've thought about these issues going back 25 years or more. For example, I was hugely influenced over 20 years ago by the book by Ian Parker and colleagues, *Deconstructing Psychopathology* (Parker et al., 1995), in which they also challenge head-on the tautological circularity of traditional psychiatry's approach to the labelling process (in relation to 'psychosis') – in their case, via the problematizing of 'normality' discourse. Thus, they show how, in the case of so-called 'psychotic thought and speech disorders':

> psychiatric research... actively constructs a version of both normal and abnormal speech, which is then applied to individuals who end up being classified as normal or abnormal.... Research draws on existing clinical categories and... its results are fed back into the diagnostic systems.... Psychiatric language, embedded in research and clinical practices, *constitutes the very 'pathological phenomena' it seeks to explain*. (pp. 92–3, my italics)

And further 'a vicious circle is created whereby diagnosis and research encourage one another leaving their assumptions unquestioned, while maintaining the same practices' (p. 97).

As you make clear, Sami, the fact that devastating arguments such as these (together with the very limited impact of Irving Kirsch's brilliant 2009 book on rates of anti-depressant prescription; cf. House, 2011) don't seem to have made any discernible impact on Psychiatry's bogus claims to scientificity certainly shows beyond any reasonable doubt that Psychiatry is very far from being 'scientific' in the accepted sense of the term, and that its pretensions to being 'scientific' are erroneous, flawed and demonstrably false. This also suggests that the attitudes and approaches within Psychiatry to such issues as evidence, treatment etc. are largely or wholly driven by culture, fashion, paradigmatic myopia and unconscious processes at both the cultural and individual level (e.g. Saul, 1999).

So in this situation, I guess all we have left is what we're doing here right now – i.e. to expose and challenge the unscientific nature of Psychiatry and its disingenuous claims – and hope and trust that rationality will ultimately prevail over what is nothing more than ideology masquerading as 'science' (and yet in the Trumpian 'post-truth' age we're now in, I fear that perhaps this is a grossly naïve hope). Certainly, the 2012 letter to the *BJP* that you described sounds like an excellent intervention in this regard. And that leaves me wondering just how open mainstream Psychiatry journals are to publishing these kinds of arguments and critiques – perhaps you could say something about that. And I'm also wondering whether there might be a sufficient critical mass of psychiatrists who think like yourself to set up an alternative Psychiatry training school that actively promotes the kinds of perspectives you're championing here and in your own writings. Might anything like that be remotely possible at the institutional level in the foreseeable future, Sami?

I was also interested in, and dismayed by, the vital point you make (which I've not really considered before) about how traditional Psychiatry practices actually *actively displace* and, at worst, completely rule out-of-court alternative treatment approaches which are likely to be far more effective than mainstream pharmaceutical approaches. This must be very disheartening and frustrating for folks like yourself; and yet in the sense that Foucault talks about, I'm assuming (and hoping!) that there are always 'spaces of contestation' within 'the system' in which you might be able to pursue alternative, more humane and effective approaches, notwithstanding the intense pressure to conform to the accepted 'regime of truth'.

Finally, I was fascinated by your phrase 'an ambivalence that neoliberal Western culture has toward children...'. I've been increasingly wondering about this very issue over the years, as I've witnessed policy-makers (and even some so-called academic experts) seemingly being completely impervious to arguments showing their policies towards children to be deeply harmful. Psychoanalytically speaking, one might even dare speak of an unconscious 'hatred' of/towards children (something that, interestingly, the English have historically been accused of). Interestingly again, one of my other great influences, Rudolf Steiner, said something a century ago about how teachers can unconsciously envy the visceral life forces of the children they teach (and of course Melanie Klein has a lot to say about the destructive power of envy). I know you wrote some interesting papers about Kleinian thinking earlier in your career, Sami, and I'd welcome any thoughts you might have on what is perhaps a very delicate area to get into.

There's a lot there – sorry if I'm hijacking *your* interview! Do feel free to respond to whatever you wish to in my over-long response above.

ST: Thanks, Richard; I like this conversational exchange/discussion style interview more than just an 'odd short question' style interview! Alternative psychiatry training is a great idea, but 'formal' training that you need for getting employed in the UK is regulated by the General Medical Council, which gives the Royal Colleges the task of setting the curriculum – so not just yet, unless by some miracle the Royal College develops insight into how power and interest affect our beliefs on what is 'evidence based' or not; but who knows what the future holds. As we have seen, seismic changes can happen very quickly when that critical mass is reached.

Just a little correction; the 2012 publication in the *British Journal of Psychiatry* wasn't a letter, but published by them as an 'editorial' (There are usually a couple of editorials at the start of each issue, which are usually by people invited by the *BJP* to write on a topical topic – all credit to them that when we approached them with our article, they decided they would publish it as an editorial).

The problem you are highlighting at the start of your reflection/question is of course that of 'scientism'. Because we live in a culture where technology and technological achievement are highlighted and promoted, and because this connects with a broader 'cosmology' that is positivist/materialist, then in order to have metaphorical and literal purchase in our society, we're inclined to use technological/scientific-sounding language. With scientism (science as a system of faith) so prevalent, eventually what the science says is almost irrelevant as long as you can look like you're doing something that you call 'science', and you can bullshit in a way that convinces others (who are excluded from language and the actual findings) that the knowledge you possess is based on a 'truth' (because you are a scientist and you do science). The hidden assumptions disappear and get taken for granted, the more you just repeat phrases like 'ADHD is a...', 'ADHD is caused by...', 'The treatment for ADHD is...' etc.

Here Foucault is very relevant, as you point out, with his analysis of how institutional power builds up and gets authority to create 'regimes of truth'. In this regime you have to keep repeating phrases like 'the evidence says...', 'studies have found...', 'evidence-based practice is...' etc. It's maddening how often I see colleagues using this without perhaps being aware themselves of how they have internalized assumption-filled notions, because that's how we talk when we become 'scientismists'!

You're also right, I think, about how resistance develops, as an understanding of the contested nature of an arena develops. This happened to some extent during the 1960s and 1970s as the writings of people like Irvine Goffman, Thomas Szasz, and R. D. Laing got exposure; and for a while, establishment psychiatry did actually wobble, until Robert Spitzer and a few of his mates (about 13 of whom had a direct input) invented the 'operational' criteria concept (a tick-list of 'symptoms' approach rather than descriptive criteria) for psychiatric diagnosis, and wrote *DSM III*. They now claimed to have solved the reliability problem in psychiatry (which they hadn't), which helped establish the highly lucrative alliance with the pharmaceutical industry. This really took off when Margaret Thatcher and Ronald Reagan pushed our economy towards rampant free marketization.

The promises made by the new approach, of psychiatric diagnoses being like any other medical ones allowing us to conduct research that will uncover causes, have failed to deliver. This became patently obvious with the publication of *DSM 5*, where no markers have been identified, and reliability figures have actually decreased. It seems that the main motivation for writing *DSM 5* was to enrich the coffers of the American Psychiatric Association, as I think it is widely acknowledged that its scientific and clinical value is zero. However, its publication has inspired new international and national alliances and protests, not only from non-psychiatrists but also from within the psychiatric establishment itself.

Francis Allen, lead editor of *DSM IV*, not only led critiques of *DSM 5*, but has admitted that the book of which he was lead editor – *DSM IV* – had many errors, leading to what he calls 'false

epidemics' of 'bipolar, ADHD and Autism' diagnoses. Other representatives of the establishment are also casting doubt on cherished concepts. For example, Sir Robin Murray, one of the leading advocates and researchers in the biological model of schizophrenia, has recently admitted that he was mistaken, and many of the neuro-imaging findings are probably caused by the medications we give to patients, with causation more likely to be psychosocial in nature.

One of the most influential child psychiatrists, who was key in popularizing the concept of ADHD – Leon Eisenberg – admitted in his last interview before his death that he had come to the conclusion that ADHD is a 'fake disorder', and child psychiatrists need to become much more adept at evaluating patient's psychosocial circumstances. Chris Gillberg, the Swedish psychiatrist who was key in expanding the diagnosis of Autism, in his recent writing has concluded that Autism is not a 'valid' diagnosis. These are just a few examples – and I'm hopeful that more will come.

With regard to the 'ambivalence' toward children, I don't think it's just hostility. It's important to appreciate what our society understands as the purpose of life and how it imagines the sort of adults we are expected/needed to grow into. Here, I believe that the structure of the economy in neoliberal societies also influences its value system, which in turn affects the narratives that people absorb, and the nature of the societal institutions with which they interact. For young people (and those in various caring roles for them) growing up in societies that promote competition and commodification puts pressure on them (and those charged with looking after them) to compete and compare. Children get inducted into 'performing' (in other words, having to do something to gain a sense of value, as opposed to being valued for just being). We are then sifted into classes of 'winners' and 'losers', and those who are deemed to fall into a 'loser' category (something that increasing numbers of young people and parents feel) then have to deal with perceiving themselves (or being perceived by others) as 'losers'.

In this environment, the individualization of identity and ambition, and the internalization of anxieties about failing (being broken or flawed in some way), together with the mass surveillance of parents and young people (by teachers, social workers, psychologists, psychiatrists etc.) and the commodification of 'soothers' for being classed a 'failure' (such as through the offer of pharmacological and psychological therapies – which are often a mixture of 'discipline' ['Stop doing that'] and 'pull yourself together' focussed interventions) – all this contributes to the rapid growth in numbers of psychiatric diagnoses given to the young, and the increasing prevalence of services and products for these diagnoses. We end up imagining we are dealing with faulty brains or dysfunctional families, and accidentally replicate the systemic hostility to those who are 'at risk' of being 'inefficient' members of the macho competitive economies our politics admire. It is ambivalence, because the winners (who also have great, but different pressures) are valorized, with hostility (masked by giving them labels like being 'vulnerable') reserved for those thought of as 'failing' in some way. Sorry for the long-winded explanation, but I hope it makes some sort of sense.

RH: Sami, I've also loved this dialogue – there's just so much enlightening critical insight in what you're saying that I'd like to see this interview as core reading on psychiatry trainings. We can but hope.... The examples you give of mainstream figures starting to point out the Psychiatry Emperor's nakedness are certainly most heartening; but the disheartening thing is how these voices only get raised when so much damage has already been done. And with regard to the issue of children, winners and losers etc., I wonder about Nick Duffell's work on 'boarding school syndrome' (e.g. Duffell, 2014; Duffell & Basset, 2016), and how our political leaders' attitude to children and childhood can so often be an unconscious acting-out of their own childhood traumata. To the extent that there's something in this (which I'm fairly convinced there is), what on earth we can do about it is a different question. But it does all seem hugely complex, and it requires dedicated and painstaking unpacking to make sense of it all; and there's so much pressure to close down critical thinking and seek superficial sound-bite 'explanations' and solutions. I'm delighted that this interview is highlighting these questions so they can at least be thought about.

Alas, due to space constraints this has to be my final question – and we have around 500 words left! Perhaps you could end by sharing your views on what concerned activists, users, academics and professionals can do to bring forward the day when we will have a truly enlightened, humanized Psychiatry in modern Western society (or is Psychiatry beyond any redemption, perhaps needing to be replaced by a fundamentally different healing practice for our 'difficulties of living'?). An absurdly big question for just 500 words, I know!

ST: A big question indeed. The only certainty I feel in answer to this is – it will change. It's impossible to say when or how, but the phrase 'you can fool all the people some of the time...' comes to mind. Perhaps, deep change isn't possible whilst we continue to be economically, and therefore politically, organized by neoliberal, ubiquitous free-market principles. As mentioned previously, the individualization of distress, locating it within broken/flawed/disordered individuals, supports rooting problems away from the alienation, discrimination and insecurity that are the hallmarks of an aggressive competitive performance-driven ideology of humanity, at the same time as opening up markets for consumption of 'snake oil' remedies for these perceived states. This means that simple-minded, disease-orientated psychiatry fulfils a vital function for the maintenance of neoliberalism.

At least a proportion of those adversely affected by the neoliberal ideology can be made to disappear as victims of cruel 'nature' for which the caring state employs heroic doctors who can fix them. Thus, mental health can be de-politicized and shifted away from making visible social realities and

from organizing to change that. Perhaps the current 'populist' backlash against established taken-for-granted politics is the first sign that something at that level may shift. Such populism has uncovered a brutal, cynical and narcissistic streak that extends the more overtly nasty side of neoliberalism, but it has also created space for genuine alternatives, including the return of the word 'socialist' to spaces where it would have been unthinkable to mention even just a few years ago. Let's wait and see how we emerge from these dangerous times.

In the mean time there are a multitude of service user and professional critiques that are emerging in all corners of the globe, that are vigorously questioning psychiatric 'norms'. The 'mad in America' website (see www.madinamerica.com) is a great resource for alternative voices and news. We also have, in the midst of disappointments like Improving Access to Psychological Therapies (IAPT), more and more organizations developing aspects of more humane, person- and community-centred services. The Open Dialogue (OD) approach is now doing trainings to services, and there are projects around Europe and North America being evaluated and demonstrating 'cost savings' (i.e. able to speak the neoliberal language of efficiency).

In the UK several Trusts (including where I work in Lincolnshire, where we now have a few staff trained in and running an OD project in one of our crisis teams) OD projects are up and running. Perhaps the most encouraging recent development, with important lessons on how to resist and create change, comes from Norway. There, after several years of lobbying through a coming together of mental health professionals (including psychiatrists) and user/survivor activists, the Norwegian government has ordered that every region in Norway should have medication-free inpatient treatment available as a treatment option. Whilst much of mainstream psychiatry in Norway has criticized this directive, the first medication-free treatment ward composed of six beds (it's a start) opened in Tromso last year (2017), led by psychiatrists enthused by this idea. I think the Norway experience may form a template of how currently disparate groups may come together to lobby around a clear focussed and singular goal, to create that starting-point. Once that foot is in the door, then, who knows?....

Richard, many thanks for inviting me to have this dialogue with you. I've thoroughly enjoyed it, and hope that it has been of some use to someone somewhere.

RH: Sami, it's great to end on such a positive note in a field which is usually unremittingly demoralizing for folks like us. This interview/dialogue has been a privilege and an honour for me. You are doing wonderful work, which I'm sure the readers of this magazine and of *Self & Society* will greatly admire. And I truly hope that what you've given us here will have a discernible impact on turning the tide and contributing to the 'critical mass' needed to shift ways of supporting in decisive, enlightened ways. Thank you!

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