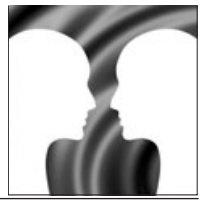
*Journal of Psychiatric and Mental Health Nursing,* 2006, **13**, 619–625



# Commentary

**Editors:**

Prof. Gary Rolfe[1] & Dr John Cutcliffe[2]

**Submissions address:**

[1]University of Wales Swansea, School of Health Science, Singleton Park, Swansea SA2 8PP, UK; [2]University of Northern British Columbia, 3333 University Way, Prince George, British Columbia V2N 339, Canada

## Post-psychiatry: good ideas, bad language and getting out of the box

### Strangled speech and linguistic politics

Psychiatric/Mental Health Nursing is perceived to be constantly changing begging the question 'where do we go from here?' – to which one answer might be, 'challenging contemporary orthodoxies and hegemonies' (Cutcliffe 2005, p. 502). Given this changing *story*, we offer a reflection on the language that typically frames it – especially the psychiatric, psychological and managerial tongues. We concentrate on the slippery language of *subtex*t – the hidden messages of human interaction. Our interest in subtext might be both old-fashioned *and* postmodern – challenging assumed certainties, and the voices of authority, which keep such certainties alive (cf. Rolfe 1999).

The British have a long-standing obsession with standard language (Blamires 1994).[1] Until the 1970s, any deviation from this standard was perceived as a threat to stability, breeding fears that the language might splinter into a thousand dialects or be undermined, irrevocably, by slang. However, dialects are fading and jargon presents a greater threat than slang, which often becomes a reputable part of the lexicon, if only because people come to appreciate the slang idiom (Howard 1978). The same cannot be said of jargon, especially in the social sciences, which frequently offers '(jargon) definitions that make obscurity more opaque' (Howard 1978, p. 15). The fear that language might lose its original meaning is an old one, parodied in Orwell's *Newspeak,* where traditional political doubletalk was so amplified that its inherent absurdity became all the more threatening. Sixty years later, *Newspeak* is thriving – especially in its political form if not also in the social sciences (http://www.newspeakdictionary.com).

Languages are plastic media, shaped and revised by native and alien speakers alike. Given its status as an international language, English is subject to almost continual remodelling, especially by North American users. However, the commonest threats come from politicians, civil servants and other bureaucrats, who manipulate the language to allow them to say one thing, while *meaning* something quite different. This fostered the assertion that English was decaying, if not threatened with death by strangulation (Watson 2004). Such threats are not concerned with the *expression* of the language – for example, bad spelling or opaque dialect. Rather, they focus on the intent to kill *meaning* – through the proliferation of *jargon*, which seeks to delimit communication, and especially *weasel words* (Howard 1978), which are as ambiguous as they are evasive. Howard (2002) attributed the popularisation of the weasel metaphor to Roosevelt, who borrowed from a story, published in 1900, in which Stewart Chaplin defined' *weasel words* (as) words that suck the life out of the words next to them, just as a weasel sucks the egg and leaves the shell '(Howard 2002, p. 637). Roosevelt worried about the political effect of weasel language in 1916, since when the weasels have all but taken over political communication.

Jargon and buzzwords disadvantage those who do not subscribe to exclusive forms of language, or who are not members of the *cognoscenti*, of whatever social class. Weasel words manipulate a subtler disadvantage, encouraging listeners to believe they are being informed, when the opposite is more likely the case. These three irritants represent the mainstay of linguistic politics, and are found, in abundance, in contemporary health and social care; especially in the policy documents that frame practice. Humphrys believed that such language existed

[1]As native speakers of lowland Scots (*lallans*), we are particular about our use of English, as it is both our 'first language' and an alien tongue.

for one purpose only – to provide *camouflage*. Protesting about the overuse of expressions like, 'delivering care to patients', Humphrys (2004, p. 165) asked, 'What is wrong with simply "caring"?' Good question!

## Metaphorical madness

Since its inception over two centuries ago, the psychiatric field has been a veritable weasel breeding sanctuary. Today, almost everyone is conversant in psychobabble, whether or not they know what it actually means (Furedi 2004). Despite contemporary claims that 'mental illness' derives from various genetic, organic, biochemical influences, *what* people *say* and *how* they say it remains the focus of practice (Smith & Kerrigan 1988, McHugh 2005). Indeed, people often avoid classification with a 'mental health problem' by electing *not* to tell others about their private experience. In law, the accused person might choose (or be advised) to remain silent to avoid incrimination. In psychiatry, such a refusal is often taken as evidence of 'psychopathology'.

Despite the oft-repeated assertion that 'mental illness' is 'just like physical illness' (Levant 2005), this is absurd. No physical procedures – blood tests, scans etc. – will reveal, incontrovertibly, the physical basis of a 'mental' illness, in the way that diabetes mellitus, leukaemia, fractures or HIV are identified. This is hardly surprising, as it is the *person* – the complex of historical and lived experience – who is 'disturbed', or disturbing to others. Most mental health practitioners acknowledge this, albeit tacitly, by inviting the person and/or the family to *talk*. If any pathology is discovered (or constructed), it will be within the emergent story, rather than the soft tissue of the nervous system. Where physical pathology *is* identifiable – as in forms of dementia – the person has a manifest *physical* disorder (not a 'mental illness'). As Szasz first noted, such physical disorders may give rise to certain psychological or behavioural symptoms, in the same way that high fever or toxicity might give rise to delirium. However, these states are never described as '*mental* illnesses' *per se* (Szasz 1960).

## Here comes everybody – the curse of political correctness

Virtually no area of human activity or experience has avoided the dead hand of psychiatry (Freud 1971) and its more recent, politically correct offspring – *mental health*. Political correctness (PC) has drained most of the meaning from what once was called 'mental illness'. As few can lay claim to full *mental health*, mental health '*difficulties*' or '*problems*' must be widespread. However, the attribution (or pseudo-diagnosis) of 'mental health problems/disorders/illness' remains in flux. Victorian society was fascinated by sexuality and, with the advent of Freudianism, sex and its manifold, putative disorders, became the backbone of many diagnostic conditions. Not least among these was *homosexuality*, which was a discrete 'illness' until 1973. The abandonment of 'homosexuality' as a 'mental illness', however, owed nothing to changes in psychiatric theory far less to research. Instead, the 'beginning of the end' for the 'homosexual illness' was the 'Stonewall Riot in 1969, when police and gays battled for days in the streets of Greenwich Village' New York (Kutchins & Kirk 1999, p. 61). This marked the start of the growing political opposition to the pathologization of same-sex relationships, and led to the annual disruption, by gay activists, of the American Psychiatric Association Conference from 1970 to 1973. The discrete category of 'homosexuality' was subsequently dropped from the Diagnostic and Statistical Manual (DSM) in 1973, and was not revived when the DSM was revised in 1980. Given that the mental health workforce includes, at least, a normative representation of gay and lesbian nurses, there has been surprisingly little discourse about the psycho-politics of sexuality. Perhaps, by deconstructing ideas like 'homosexual illness' one runs the risk of deconstructing other, no less fragile ideas about 'mental' or 'emotional' *illness*.

## The long psychiatric shadow

The last 25 years has witnessed also the 'reclamation' of terms like 'madness' and 'crazy' by activists and consumer groups, as a defiant act of subversion (Barker *et al*. 1999, Newnes 1999). The history of the 'voice-hearing' movement reveals the extent to which people accorded 'psychotic' diagnoses, reject the psychiatric world view, in their attempts to find meaning in their experience (James 2001). More recently, 'Mad Pride' has become an international platform for celebrating diversity and difference. What mental health nurses make of these overtly political and challenging developments remains unclear. Where nurses

have engaged with such alternative conceptualizations, the defensiveness, if not folly, of traditional diagnosis-governed approaches, becomes all too apparent (cf. Martin 2000).

The contemporary focus on 'mental health' and its assorted 'problems or difficulties' cloaks the irony that few physicians – or other health care workers – talk about their work with 'physical illness' – far less physical *health difficulties*', if they can talk about specific diseases or disorders, which they had examined *clinically*, and measured *reliably*. Illnesses and disorders either show manifest lesions of the body – like the various cancers – or signal potentially dangerous disturbance of bodily functioning – like high blood pressure. That they are both identifiable *and* measurable makes physical medicine a genuine scientific enterprise. By contrast, the notion of psychiatric 'medicine' is almost a contradiction in terms. Bentall (2003) argued that psychiatric diagnoses are no better predictors of what will happen in a person's future, than horoscopes. When people become seriously ill, they expect blood tests, urinalysis, X-rays, biopsies, magnetic resonance imaging scans, which will, hopefully, identify what is wrong. People deemed to have a 'serious mental illness' will have a conversation with a psychiatrist, who makes a judgement based on what has been *seen* and *heard*, thus making the parallels with astrology all too evident.

Collapsing the huge catalogue of stories of human misery into the rag-bag classification of 'mental illness', makes no *logical* sense, but perfect *historical* sense. Psychiatry may not have invented 'distress' and 'disturbance' but by attributing these various personal and interpersonal problems to some putative 'disturbance of the mind', psychiatry constructed our contemporary medical notion of 'mental illness'(Szasz 1960). In common with conservative politicians, many conservative psychiatrists exhibit a tendency towards black-and-white thinking. If we are not actively *pro-psychiatry* then we must, perforce, be *anti-psychiatry*. Critical psychiatry cannot exist as psychiatry must be beyond criticism. Such a contentious view, is invoked by the likes of Sally Satel (2002), who is typical of the conservative psychiatric lobby, viewing any change–even at the linguistic level, such as 'consumer-survivor' – as a threat to medical hegemony. Satel is even dismissive of mental health nurses who have 'spoken out' against the negative effects of a male-dominated medical system: another example of 'PC gone wild'. Ironically, Satel is a woman, but clearly she is no 'sister'.

## Post-psychiatry

Some psychiatrists have tried to redeem themselves by reviving old ideas like the 'biopsychosocial' model, which they hope will counter the reductionism of the 'medical model', without altogether abandoning scientific psychiatry (Double 2005). Foremost among these advocates of an alternative psychiatric paradigm are Bracken & Thomas (2001) who first posited the idea of 'post-psychiatry', wondering what psychiatry would be like if it could accommodate contemporary *philosophical* positions – regarding the self, citizenship, lived experience, community, race, power, etc. Their work has gone some considerable way to answering such questions – and to realigning at least their own practice. However, by revising psychiatry, they avoid addressing the forces that sustain psychiatric medicine. In particular, they avoid asking the most obvious question: what would a world *without* psychiatry be like?

Traditionally, the psychiatrist (usually male) was depicted as a humane, insightful, scientific, 'healer of the mind'. Cinema – especially post-world-war II (Gabbard & Gabbard 1999) – nurtured such sympathetic, if romantic stereotypes, and today celebrity psychiatrists and psychologists – from American television's 'Dr Phil' to the UK experts from BBC radio's 'All in the Mind' – reinforce the public need for paternalistic, renaissance men and women, who can diagnose our ills, offering a pill or therapy for all that ails us. However, in the spirit of 'post-psychiatry' one might ask 'what, *exactly*, do psychiatrists offer us today?'

- *Psychological help?* Apparently not. If people need or want psychotherapy or counselling they usually see a psychologist or some other 'therapist' – at least in the UK.
- *Practical help?* Apparently not. If people need help to sort out their everyday problems, they see a social worker, or some other 'mental health worker;
- *Human support?* Again, apparently not! If people need someone to comfort them, during a crisis – they are more likely to turn to nurses, other 'support worker', members of a mutual support group, probably comprising other 'patients', if not their family and friends.

In the UK, the delivery of a psychiatric *diagnosis* and the prescription of psychiatric drugs is *currently* what people expect from a psychiatrist. However, one might ask – 'for how much longer?' Mental health nurses in the UK are being prepared to become 'prescribers', following the lead of their American cousins, who have been prescribing for over a decade. US nurses have also been taught to deliver psychiatric diagnoses, a similar development seeming inevitable in the UK. (How many American nurses actually prescribe may not be as relevant to the debate as the importance attached to prescribing as part of the 'advancement of practice'.) However, appropriate 'drug treatment' is – at least in medical principle – dependent on accurate diagnosis. As the development of 'nurse prescribing' appears driven more by political-economic imperatives than professional discourse (Cutcliffe 2002), other 'principles' might well be at work.

If people do not *need* psychiatrists for psychotherapy or counselling, or practical help, or ordinary human comfort, or to deliver a diagnosis or prescribe medication then what, exactly, do people need them for? It seems like a straightforward question.

## Getting out of the box

Psychiatrists like Bracken and Thomas recognize that few of the core concepts of psychiatry make any scientific sense, and even have asked for ideas like 'schizophrenia' to be scrapped (Bracken & Thomas 1999). As psychiatrists themselves, however, they stop short of suggesting that psychiatry itself might be scrapped, and who can blame them. However, if society is to address the burgeoning catalogue of human misery (and social disruption) presently embraced by the concept of 'mental illness/disorder/health problems', then envisioning a 'post-psychiatric' society might be a necessary part of the process. In management-speak, people involved in the mental health business need to 'get out of the box'. All relationships involve exchanges and all exchanges are run by rules that define and limit these exchanges. Professional relationships within psychiatry are governed by rules – many tacit and covert – that have evolved over the past two hundred years. Foremost among them is the presumption (rather than fact) of the pathological basis of 'mental illness'. This provides a rationale for medical hegemony and the preservation of psychiatry as a medical speciality. If we accept this rule, this helps us understand why even 'critical' psychiatrists, such as Bracken, Thomas and Double, do not take their critique of psychiatry to its logical endpoint, settling instead for revisionism.

Two hundred years ago, when modern psychiatry began, the abolition of slavery had not yet started, and few would have considered the possibility of a 'post-slavery' society. In the early 1900s, as Freud began to shape many of our current ideas about the mind and brain, women had yet to gain the vote, and the idea of a 'post-women's suffrage' society was anathema to most men, at least. In 1960, when Thomas Szasz first laid down his challenge to the orthodox logic of psychiatry, the American civil rights movement was just beginning and few thought then that we would ever talk 'post-civil rights' so easily. In 1990 as Ronald Reagan announced funding for the 'decade of the brain', the Soviet Union began to implode, but few would have believed that 15 years later, we would talk so casually about 'post-communist societies'. These historical timelines remind us that all institutions and ideas have a limited lifespan. Nothing endures. In principle, at least, that should include psychiatry.

These events also remind us that the key issues in contemporary society are about *personhood* (slavery) *equality* (suffrage) *humanity* (rights) and *power* (scientism or communism – take your pick). Bracken and Thomas offered a valuable, if complex, philosophical rationale to 'post-psychiatry'. Is it really so difficult to understand why we should look critically at slavery and power while encouraging suffrage and human rights?

## Madness, mental illness or problems of human living?

Clearly, some people experience serious problems in their lives, which *may* be the result of 'bad luck' in the gene pool or a 'bad draw' at the social card table – poor parenting, poverty, sexual, physical and emotional abuse, or multiple other forms of social deprivation. However, some people's problems derive from bad choices: substance abuse, poor diet or other forms of physical or interpersonal risk-taking. In that sense, people contribute, often significantly, to their own hard luck story. It may not be PC to say so, but it demeans such people to pretend otherwise. However, at least within contemporary societies, the idea that there might be one single 'cause' for complex problems of human living is no

longer tenable. Even where manifest brain pathology might 'explain' the features of certain human problems, the complex interplay between personal experience and interpersonal and social exchange, generates the distinctive character of the problem. It is meaningless to ask how we might *remedy* such problems, as if they were singular pathological phenomena – 'the problem is life, in the social not the biological, sense . . . a person beset by difficulties in his life can reflect on how he lives and change some of his habits. He can educate himself about the sort of problem he is experiencing and seek help from family members, friends, clergymen, mental health professionals, physicians, drugs, religion, faith healing, marriage, divorce and so forth. . . . The possibilities are too numerous to mention' (Szasz 2004, p. 162).

Dyslexia is described variously as a neurological disorder, learning difficulty or language-based disorder, and affects about 10% of the population, regardless of intelligence, race or social class. Although focused mainly on difficulties with reading, writing and spelling, other 'mental' or neurological problems may be evident, affecting short-term memory, concentration and personal organization. Dyslexia is now recognized as having a biological basis and, given that it runs in families, also has some genetic influence. However, despite these biological, genetic aetiological underpinnings, dyslexia is never addressed as a *mental illness*. People affected by dyslexia need understanding, support and practical help in learning to live with, or overcome their specific problem in living. They do not need to see a psychiatrist. Although the presence of serious problems in reading, memory, comprehension and concentration could, potentially, be lethal, the person with a diagnosis of dyslexia is not a candidate for detention under 'mental health' law and subsequently the recipient of enforced 'psychiatric treatment'.

Consider also people with so-called 'learning difficulties/disabilities'. Less than 20 years ago, most people with 'learning disabilities' were still in the 'care' of psychiatrists, although then described as 'mentally handicapped' or 'mentally subnormal or deficient'. Today, it is accepted that the cognitive, emotional, intellectual and other 'mental' difficulties of such 'learning disabled' people arise from brain injury, organic defect, chromosomal abnormality or various genetic influences. However, despite the obvious 'medical' nature of many of their problems, people with learning difficulties have – over the past two decades – almost completely escaped the dead hand of psychiatry. They may well experience complex problems of living – with themselves, other people and the world at large, and as a result may need a variety of the forms of human helping referred to by Szasz: from special education, through special social support to special housing. What they do *not* appear to need – despite their obvious brain pathology – is a psychiatrist. Indeed, the success of most contemporary learning disability services worldwide involved the reclamation of personhood (and citizenship) of people with the so-called learning disabilities *thus* ditching psychiatric paternalism in the process. What began as a radical *rethink* in the field of learning disability is only slowly insinuating its human values into the 'mental health' arena (Flynn & Lemay 1999).

## Getting over psychiatry

However, having invented itself two centuries ago, psychiatry will not simply walk away from the action. Despite unremitting criticism over the past 30 years, psychiatry still reigns supreme. As Gabbard & Gabbard (1999) noted, from the mid-1960s onwards cinema portrayals of psychiatrists shifted from the stereotype of the 'psychiatric healer', to evil, exploitative, agents of a repressive society. However, the 'church of psychiatry', like other beleagured, outmoded religious institutions, manages to retain its power, perhaps by encouraging poor, unfortunate, fearful people that they might *need* the succour psychiatry has to offer. In the more cultured world of the chattering classes, psychiatrists seek to present a more intelligent rationalization of the public need for psychiatry – and psychiatrists. McHugh (2006) has been hailed as one of the most important influences in American psychiatric education and practice. In his view: 'Psychiatrists attend to and become expert in all disorders that manifest as changes in mental life, regardless of the causes, mechanisms, or treatments' (p. 165). Reflecting on his chosen discipline's future, McHugh asserted that:

'We must emphasize that a psychiatrist's domain of expertise embraces every disruption of mental life from mental retardation to dementia, from abnormal hungers to grief. Then we can show how information derived from knowledge of particular afflictions and from basic research can be programmatically deployed to teach medical students,

residents, interested onlookers in other specialities, and, lest I forget, administrators, deans, and presidents of our university centers about the field. These people must be turned into active collaborators in the production of the emerging psychiatry' (pp. 165–6). Given that his book was aimed at an even wider readership, perhaps McHugh hoped to recruit the layperson as another 'psychiatric collaborator'.

The reader might well ask – what is wrong with galvanizing the public understanding and appreciation of a discipline such as psychiatry? In principle, nothing! However, McHugh's appeal appears centred on the reinforcement of an outmoded form of psychiatric *medicine*, seeking to reinforce the:

> emphasis, led by senior *clinicians*, on *bedside* and *outpatient* teaching, where the basic features of each *disorder* can be exemplified, differentiating what is common to each condition from what is idiosyncratic to the *patient* at hand. This teaching should go on regularly in the form of *rounds*, *clinical* services, *grand rounds*, and *journal club*. (p. 166: emphasis added)

McHugh's ambition for the early 21st century differs little from the language of the early days of the 20th century, except that he has dispensed with the rhetoric of Freudian psychology, opting instead for the near-categorical assertion of psychiatrist's status as a renaissance figure:

> There should be no mystery about what psychiatrists *can* do. They can heal the symptoms of some diseases; guide and protect a patient from the promptings of temperament; interrupt destructive behaviours, such as addiction; and help patients rethink their assumptions so as to enhance their capacity to deal with the present and the future. (McHugh 2005, p. 29)

No doubt *some* psychiatrists *can* do all these wonderful things, and are sophisticated communicators, warm and compassionate individuals, with an encyclopaedic knowledge of both the physical and social sciences. However, is it necessary to spend a decade or more training as a *physician* to be useful to people with such different problems of human living? More importantly, do people with *serious* 'mental health' problems need such a brilliant mind, to supervise their everyday 'care and treatment'? People with learning disabilities or dyslexia don't, so what apart from history is different about people who fall within the ambit of 'mental health'? Clearly, that is not such a good question. History is so critical to 'psychiatric medicine' that it is almost impossible to think about it, far less 'rethink' it, without the frame of history. However, if people with any kind of vested interest in 'mental health' – whether users/consumers, carers, professionals or interested lay public – wish to advance this aspect of the human services, then they might need to consider 'getting out of the box', so that they might see the lie of the human territory beyond the confines of the psychiatric system.

We have focused on psychiatric medicine as the parent figure in the psychiatric family: the metaphorical rulers of the psychiatric household, where psychology and social work are probably the uncles and aunts. We intend no disrespect by locating mental health nursing as the adolescents within this family: still uncertain of their identity; talking a fair bit about breaking away; but still perceived by the neighbours to be tied to the apron strings. Perhaps the family metaphor is apposite.

Families are changing and many of the old conventions are disintegrating. New kinds of human relationships are developing alongside new forms of community membership. In a very real sense, human society is engaged in a form of *deregulation*: asking profoundly simple questions like – 'what do we need and how might we organise this'? These questions have been asked *and* answered, powerfully, by a range of interested parties in the field of psychiatric survivorship and mental health recovery (Newnes 1999, James 2001, Read *et al*. 2004).

We asked: *what do people need psychiatrists for*? By implication, this begs the question, what need is there for *any* of the other members of the psychiatric household? Our irreverent reflection might represent one response to Cutcliffe's (2005) call to challenge orthodoxies and hegemonies.

*P. BARKER*
*Visiting Professor, Trinity College Dublin, Ireland*
*E-mail: phil.j.barker@btinternet.com*
*P. BUCHANAN-BARKER*
*Director, Clan Unity International, Scotland*

## References

Barker P., Campbell P. & Davidson B. (1999) *From the Ashes of Experience: Reflections on Madness, Recovery and Growth*. Whurr, London.

Bentall R.P. (2003) *Madness Explained: Psychosis and Human Nature*. Penguin, London.

Blamires H. (1994) *The Queen's English: The Essential Companion to Written English*. Bloomsbury, London.
Bracken P. & Thomas P. (1999) Let's scrap schizophrenia. *Open Mind* **99**, 16–17.
Bracken P. & Thomas P. (2001) Post-psychiatry: a new direction for mental health. *British Medical Journal* **322**, 724–727.
Cutcliffe J.R. (2002) The beguiling effects of nurse-prescribing in mental health nursing: re-examining the debate. *Journal of Psychiatric and Mental Health Nursing* **9**, 369–375.
Cutcliffe J.R. (2005) A few comments on the commentary section: editorial guidance for authors. *Journal of Psychiatric and Mental Health Nursing* **12**, 502–503.
Double D. (2005) Paradigm shift in psychiatry. In: *Mental Health and the Crossroads* (eds Ramon, S. & Williams, J.E.), pp. 65–80. Ashgate, Aldershot.
Flynn R.J. & Lemay R.A., eds (1999) *A Quaternary Century of Normalization and Social Role Valorization: Evolution and Impact*. University of Ottawa Press, Ottawa.
Freud S. (1971) *The Psychopathology of Everyday Life*. WW Norton, New York.
Furedi F. (2004) *Therapy Culture: Cultivating Vulnerability in An Uncertain Age*. Routledge, London.
Gabbard G.O. & Gabbard K. (1999) *Psychiatry and the Cinema*. American Psychiatric Press, Washington, DC.
Howard P. (1978) *Weasel Words*. Hamish Hamilton, London.
Howard P. (2002) *The Macmillan Dictionary of Contemporary Phrase and Fable*. Macmillan, London.
Humphrys J. (2004) *Lost for Words: The Mangling and Manipulating of the English Language*. Hodder and Stoughton, London.
James A. (2001) *Raising Our Voices: History of the Voice Hearing Movement*. Handsell, Gloucester.
Kutchins H. & Kirk S. (1999) *Making Us Crazy: DSM – The Psychiatric Bible and the Creation of Mental Disorders*. Constable. Free Press, New York.
Levant R.F. (2005) Serious mental illness, recovery and psychology. *Monitor on Psychology* **36**, 5.
McHugh P. (2006) *The Mind Has Its Mountains: Reflections on Society and Psychiatry*. Johns Hopkins University Press, Baltimore, MD.
Martin P.J. (2000) Hearing voices and listening to those that hear them. *Journal of Psychiatric and Mental Health Nursing* **7**, 135–141.
Newnes C., ed. (1999) *This is Madness: A Critical Look at Psychiatry and the Future of Mental Health Services*. PCCS Books, Ross-on-Wye, Herefordshire.
Read J., Mosher L. & Bentall R.P. (2004) *Models of Madness*. Brunner Routledge, London.
Rolfe G. (1999) The pleasure of the bottomless: postmodernism, chaos and paradigm shifts. *Nurse Education Today* **19**, 668–672.
Satel S. (2002) *PC, MD: How Political Correctness is Corrupting Medicine*. Basic Books, New York.
Smith J.H. & Kerrigan W. (1988) *Taking Chances: Derrida, Psychoanaylis and Literature*. Johns Hopkins University Press, Baltimore, MD.
Szasz T.S. (1960) The myth of mental illness. *American Psychologist* **15**, 113–118.
Szasz T.S. (2004) Reply to slovenko. In: *Szasz Under Fire: The Psychiatric Abolitionist Faces His Critics* (ed Schaler, J.A.), pp. 159–178. Open Court, Chicago, IL.
Watson D. (2004) *Watson's Dictionary of Weasel Words. Contemporary Clichés, Cant and Management Jargon*. Knopf, New South Wales.

Commentary