

**ShrinkRapRadio #503, April 21, 2016, Exploring The Disease Model Debate
David Van Nuys, Ph.D., aka "Dr. Dave" interviews
Professor Peter Kinderman**
(transcribed from www.ShrinkRapRadio.com by Yann Derobert)

Introduction: My guest today is University of Liverpool professor of clinical psychology, Peter Kinderman, PhD. And we'll be discussing his open letter to the BBC about their biased coverage of mental health issues in recent programs. For more information about Dr. Peter Kinderman, please see our show notes at ShrinkRapRadio.com. Before we go to the interview, let me mention that this week's featured article in the Neuropsychotherapist is *Transgenerational Trauma: Development of a Neurobiological Therapeutic Tool* by Cassandra Garmston. You'll find it at the Neuropsychotherapist.com which is the beautifully illustrated online monthly magazine for psychotherapists and anyone else interested in the intersection between the latest neuroscience findings and psychotherapy. I want you to go to Neuropsychotherapist.com and get your free introductory issue today. And I'm hoping that it will inspire you to support their superlative work by subscribing to it. Now, here's the interview.

Dr. Dave: Dr. Peter Kinderman, welcome to Shrink Rap Radio.

Peter Kinderman: Hi! Yeah, good to be here.

Dr. Dave: Well, I'm pleased to have you on the show. Before we get into our main topic, maybe you could give us a little background on yourself?

Peter Kinderman: OK.

Dr. Dave: For example, when did you... when and how did you decide that you wanted to be a psychologist?

Peter Kinderman: So, I've been a clinical psychologist now for I think 25 years, cause I'm very old! And I studied what was called natural sciences at university and it's a degree where you start off studying all of the sciences and for probably very good reasons that university I went to they didn't offer psychology in the first year.

Dr. Dave: Hum.

Peter Kinderman: So, I went through... I got more and more interested in psychology and I guess like lots of people I realized that it spoke to issues that were important to me in my personal life. So I found it fascinating, I found it interesting, I found it engaging. So when I left university I worked as an assistant psychologist in the National Health Service and just went up through the ranks and stayed there all the time.

Dr. Dave: Well, at what point did you decide that you wanted to move in the clinical direction?

Peter Kinderman: I think it was after university, I was just talking to tutors at the university about possible options and looking back, it was extremely relaxed. They suggested that if I wanted to go into clinical psychology, I should work in the National Health Service, work as an assistant, see what it's like, see if that was the career that I wanted to go in. I thought I'll give that a bash, see where we go to. It didn't seem as pressurized 25 years ago in terms of paying off loans and careers...

Dr. Dave: Oh yeah...

Peter Kinderman: ... and things as it is now.

Dr. Dave: Yeah. So you have those issues over there too?

Peter Kinderman: Well we made the tremendous mistake that I seriously hope our North American cousins won't make which is we elected a right wing government. And you know what? They did exactly what they promised.

Dr. Dave: Oh yeah! That's what right wing governments do! And we're always shocked! That when it happens: "Oh no! They didn't really mean it". Yes they did!

Peter Kinderman: They said that the poor would have to pay for everything and the rich would get away with offshore tax heavens and remarkably that's precisely what they delivered for us, yes. It's our fault. It's our fault.

Dr. Dave: I'm sure you're following our current election and we won't go there. But... And elections aren't even upon us yet but we've been dealing with debates and so on ad nauseam.

Dr. Dave: (laughs) Okay, well, let's get into the reason I reached out to you. I was contacted by one of my listeners who said there was a raging controversy there in the UK. And it was centered around a series of BBC programs on mental health. So tell us about that kerfuffle if you will.

Peter Kinderman: Well, I mean, the BBC is one of the sort of much loved institutions in the UK.

Dr. Dave: And here too, I might add.

Peter Kinderman: Absolutely. Yeah, I mean they export a lot of good things. And a producer at the BBC lead the way in proposing and then delivering a really, very positive to be honest, series of programs about mental health. And he didn't actually commissioned lots of new programs but it involved greater attention on mental health, greater focus on mental health, reflecting discussions that are happening in other parts of the media, even in politics for example. As a part of it, they commissioned some new programs. And myself, my friends both in this sort of critical psychiatry movement and the sort of more progressive parts of clinical psychology, were disturbed by not all of the programming, not all of the news reports but some of the programs seemed to have an extremely biomedical reductionist slant to them. And we paid attention to that, we drew attention to that rather, and we wrote a letter, an open letter to the BBC director general raising our concerns about the very biomedical as we saw it quite reductionist slant of some of the programs that were part of this series.

Dr. Dave: You used the term "critical psychiatry" and I don't think I've heard that term before.

Peter Kinderman: So, in the UK, there's been a tradition I suppose of psychiatrists, from R.D. Laing, Thomas S. Szasz of course, but R.D. Laing through a strong tradition of psychiatrists who focused on social perspectives on I guess the medical tradition, the healing tradition of medicine rather than the sort of biomedical science tradition of psychiatry. And so there is in the UK a network called Critical Psychiatry Network, and a number of the leading lights in British psychiatry are also leading lights of that network, and there are various ways in which those psychiatrists with a social psychiatry, more socio-deterministic strand, touch up against clinical psychologists

who are sort of like minded. So there's a set of nested diagrams of more socially focused psychiatrists, less biomedical psychiatrists with clinical psychologists who come from the same ilk and, like I said, there's a group called the Critical Psychiatry Network, which is quite an active group of psychiatrists.

Dr. Dave: Okay! That's interesting. I wasn't aware of that. Now, you've written about what you feel is an excessive focus there on biomedical issues rather than what you've referred to as "genuine biosocial approach". What a genuine biosocial approach look like?

Peter Kinderman: Well, it does get interesting and contentious. There was debate over the weekend actually between a number of clinical psychologists talking about this, where that question "what "genuine" means?" and in our case it was a question of what "fundamental" meant. So I think one of the tropes that we were talking about is something that was reflected in Eric Kandel's paper back in 1989, A New Intellectual Framework for Psychiatry.

Dr. Dave: Oh! The video froze for a moment but it looks like you're back. And so repeat whatever you were saying, you were just talking about Eric Kandel.

Peter Kinderman: Yes. So, he made the point that every phenomenon that impacts on our lives evolves by chemical changes in the brain. And he also argued that psychotherapy if it was successful, and I suppose if it were unsuccessful, has to achieve its effects through changing synapses. That was repeated by Thomas Insel recently, who made a quote saying, something on the lines of all psychological phenomena are brain events. And there was actually an editorial in the British Journal of Psychiatry only a few days ago again making the same point, and one of the phrases in that one argued that

psychotherapy, because it results in brain changes, should be considered a form of medication. Now what's interesting about those from those of us who are critical of that bio-reductionist perspective is... I think what we think is un-genuine about that I suppose, is the idea that that means that the most fundamental and the most important way to understand these sorts of issues is in terms of changes at the level of the brain. And our perspective I think would be that, not deny all of biochemistry, not deny all of genetics but to ask: "What purposes do they serve?". So if for instance, you know, talking about genetic differences between people, that seems to be related to mental health issues, the question then would be: "What impacts do those genetic factors have on psychological issues? How do they change the way that people make sense of the world?". So if for instance you're looking at the research that Tim Crow, former professor of psychiatry at Oxford, worked on, which is about the way in which we process information about language, and genetic factors impacting on our use of language. There's obviously a relationship between those sorts of issues and auditory hallucinations. And the way in which we go about separating out things that we hear from things that we think clearly involves language processing in the brain. So for us the genuineness is not to say: "Therefore auditory hallucinations are symptoms of a biological illness", but to ask the more genuine question, which is: "How does that biology serve the psychological processes by which we relate to other people, manage our emotions, make sense of the world?". So, for us, I think, the genuineness comes that the brain is an organ, the organ with which we think. But it's thinking, and feeling, and emoting, and relating, and behaving that's the fundamental part of what makes us human. The biology serves that fundamental purpose, but the biology isn't the be-all and end-all of what it is to be human.

Dr. Dave: Yes. So at least part of what you're saying is: there's a

strong correlation between what's going on in the brain and what's going on in life, but it's not necessarily a causal relationship.

Peter Kinderman: That's true, but also, and it's also not necessarily unidimensional, unidirectional. So for instance if you are exposed to a great deal of environmental stress, it will change your biochemistry. In fact if you just close your eyes, it will change your biochemistry. When you put people into a fMRI machine and you watch their neuro-activity in terms of the electrical activity in the brain, when we close our eyes and when we open our eyes, it changes blood flow, it changes the biochemistry of the brain, it changes the electrical activity of the brain. But that's the brain responding to the environment. So, part of it is a correlation, which is what we see at the level of the brain correlates with what we see at the level of our emotions, and our behavior, and our thoughts. But it's also the case that sometimes the things that happen at the level of the brain and biochemistry are indeed causal. But what's interesting I think at least for me and I think for my colleagues is that even when biochemical genetic factors can be causal, there's also a question of what that means for us as human beings. So, for instance, if I were born with a tendency to respond, a biological tendency to respond very fearfully to threatening situations then, for me, what's fundamental is that's who I am, that's how I work. I know I can learn to live with that, I can learn to respond to that. I'm not going to go around the world saying: "What's fundamental about me is the way in which my biochemistry will move serotonin from the space between my neurons". What's fundamental is whether I get fearful in certain situations. So, part of the genuineness is even when the biochemical factors, when the genetic factors are causal, they serve a purpose. And what's central to us as human beings is how we make sense of the world. So, you're actually right, part of the argument is some of the issues which the biochemical theories talk about may be just correlations of other events in people's

lives. But even when they're causal, I think what's fundamental to us as human beings is how we think, how we relate, how we make sense of the world. An analogy I've used in other places is modern mechanized warfare is not fundamentally about the twitching of white men's trigger fingers, it's fundamentally about power politics. The twitching and triggering is the mechanism by which we wage war, that's not fundamentally what the war is. And similarly, serotonin, dopamine, GABA, neurotransmitter activity isn't fundamentally what it is to be human.

Dr. Dave: Yeah. Now you mention some research and another researcher, that you mention in something of yours that I read, was Emma Williamson and something called the "Waterloo Project" and that was fascinating, maybe you could take us through that?

Peter Kinderman: I think that's another example of what I mean about that sort of genuine and fundamental nature of a psychosocial response. So Emma is a clinical psychologist who works in London, in a very deprived area of London, in a hostel for homeless people. And when you end up sleeping rough on the streets, typically you have a wide range of different problems in your life, including often very serious mental health issues. So, people are often... they use street drugs, they use alcohol a lot, they've often been in trouble with the police, their relationships have often broken down, and they've often developed really quite dysfunctional ways of relating to other people. Plus, they're often in debt, they're often physically unwell, there's a whole range of problems. So Emma works as a clinical psychologist within that hostel for homeless people, pulling together the different strands of social and physical and emotional needs that they have, helping with a multidisciplinary formulation to see about how services can be directed to help people in very great distress. And I think that as a model for working is a very powerful way of saying how we, in

multidisciplinary teams, can pull our expertise together, to make sense of the social, environmental, the personal, and also the biological factors that impede on people's lives, come up with a plan for what might be a route towards recovery for them.

Dr. Dave: Yeah. You've written: "To promote genuine psychological health and wellbeing, we need to protect and promote universal human rights." Now, that would suggest that mental health is maybe a political issue at root.

Peter Kinderman: I think it is. I mean, one of the pieces of research that I've been involved in, I've been part of, because the research has been produced in research groups I've been part of, was a work by Filippo Varese and Richard Bentall and others looking at a meta-analysis of the relationship between trauma in childhood and the development of psychosis in later life. And one of the striking quotes that comes out of that, my colleague Richard Bentall uses is: "The statistical relationship between multiple traumatic events in childhood and the later development of psychotic experiences is statistically greater than the relationship between cigarette smoking and squamous cell carcinoma". Now, of course, there's a biological root between the carcinogens in cigarette smoke and carcinoma and lung cancer as fundamentally a public health issue, at least in a large part. And yet when we look at psychosis and we look at mental health, the bio-reductionist model, at least to many of us who are critical of it, would suggest that we really need to see this as an illness to be treated. So the point of focusing on human rights is to suggest that when people are made unemployed, when people are in debt, when people are made homeless, when people are abused, when people are exposed to refugee status, they lose their homes, when people are traumatized, when people are assaulted, and when people are impoverished, then it impacts on their mental health. And that's not to

deny the role of biology in mental health problems, but it's to make sure that we, at least, pay due attention to the social, and yeah, as you say, the political aspects to this. You know, mental health is in part a process of poverty and abuse, and so, for me, it's equally valid to analyze that from a social, from a political as well as from a psychological, and then a medical perspective, absolutely.

Dr. Dave: It occurred to me, a kind of a devil argument might be: "The poor have always been with you", right? And so, poverty, war, and all those sorts of disasters have always been with us. Governments have always... maybe not always but for a long time now, given lip service to social... to the betterment of social conditions, that's what government is supposedly for, and yet, so much of that just doesn't change. So it makes me wonder, if that sort of a very nice ideal, that we need to change things for people at the bottom of society but, in the meantime, what do we do? What does the clinician in his office or her office do with the folks today?

Peter Kinderman: Well, I'm not sure if I have total sympathy for that. Because if we extend that argument too far, what we say is: "The poor have always been with us", I would add: "And the poor were being continuously harmed by that poverty", but if we don't pay attention to that, we don't pay attention to this. What I'm saying is we need to pay attention to both. I mean, if the wealthiest person in the United States of America was currently experiencing emotional distress, I think we have a moral duty to offer him or her therapy. We need to find out why they're distressed, and we need to offer them help with their problems. I don't think we should deny help to wealthy people. But equally, we know that mental health problems disproportionately affect poor people, minority ethnic groups, people who've been abused, people in difficult social circumstances. We also happen to know that more unequal countries like the United Kingdom,

I have to say, have higher rates of more serious mental health problems than more equal countries. So, for me, I think it more of an onus, I suppose on people working in mental health to look at social and preventative factors as well as treatment factors. So clearly we need to offer people therapy, we also need to be offering people practical solutions to their problems. So, you know, when people are struggling with the emotional and relationship consequences of debt, we also need to offer them practical help with indebtedness. We need to see whether there are practical and financial solutions that can be part of the picture, as well as therapeutic solutions. I think if people are being emotionally damaged by the relationships that they're in, for instance if they've got abusive partners, then what we need to do is work with them to change or escape from those relationships, as well as offering them therapy to cope with the emotional damage that's been caused. So I guess my answer is: the poor have always been with us but I don't therefore conclude that we should do nothing about that.

Dr. Dave: Right.

Peter Kinderman: I think that the analysis that I'm putting forward suggests that there is scientific evidence coming from the psychological and psychiatric fields to add weight to the idea that social, economic and even political activity is just as valid as medical psychotherapeutic and social work intervention for people. So, yeah, no, I plead guilty to being a social and political activist, but I think the evidence points towards the conclusion that that's exactly what we should be doing.

Dr. Dave: Well, good for you! And you argue that we need to abandon the disease model of mental health care and you even write that... you say "even main stream medical authorities have begun to question the

creeping medicalization of normal life and criticize the poor reliability, validity, utility, and humanity of conventional psychiatric diagnoses”.

Peter Kinderman: Yes. So, we see that... a number of persons... and I think it's important to stress... I mean, some of my colleagues in the UK have been quite critical of the idea that I have myself criticized the medical model. And I try to take care to criticize the disease model rather than the medical model. Though I think that my colleagues who are medical practitioners absolutely have a role to play, I don't think that the metaphor of disease is a useful metaphor. So you can't say this just out of shot. I have framed on the wall of my office the front cover of the British Medical Journal from the date of the publication of DSM-5, back in May 2013 I think. And it's got a... I'm looking at it now, it's got the face of a man covered in Post It notes, and in big red letters it says: "Too many labels? The controversy over DSM-5". Now, admittedly there's a question mark at the end of that. But I think that it's clear that the BMJ and other medical journals raise questions over the validity, utility, reliability of standard diagnostic practices. And of course ICD 10 and DSM-5 are really not very much different. That's in the BMJ. The Lancet, at the same time, published an editorial specifically focusing on the issue of the diagnosis of major depressive episode, major depressive disorder, when people are grieving over the death of loved ones, and asking the question that while we recognize that it's wise and valid and humane to identify distress in somebody who's recently lost a loved one, is it appropriate to diagnose them with a mental disorder? Does it make sense to suggest that they, or their problems, or their reactions is in some way disordered that they haven't recovered from their grief in the normatively accepted time frame? And so there's the... the criticism within psychiatry of too many labels, are we labelling people inappropriately? And in that case, in the example of grief, yes, I do think that mainstream medical colleagues are questioning not that we should not help people, but they're

questioning whether the idea of disorder is appropriate. So veterans return from war and they've been traumatized by what they've experienced, and one way of putting it is they are experiencing post traumatic stress. Is that disordered? I'm not sure that it's a useful metaphor. I think they're upset...

Dr. Dave: Yeah.

Peter Kinderman: I think it's causing damage to them. I think that the consequences damage other people. And that's the consequence of warfare. Is it disordered to be traumatized by warfare? I think it's traumatic to be traumatized by warfare. But I'm not sure that "disorder"... "distress", yes, "disorder", no. So the idea of the disease metaphor I think is crumbling. Attention Deficit Hyperactivity Disorder? I mean, you know... Some kids find it difficult to pay attention, there's always...

Dr. Dave: (laughing) That's always been true.

Peter Kinderman: It's always been true and in the DSM-5, as Phil Hickey pointed out, the diagnostic criteria for Attention Deficit Disorder sound like a description of a normal childhood, in many ways. And there's Caffeine Dependence Disorder, Social Anxiety Disorder, I mean, what benefit do we conceivably get from adding the word "Disorder" to social anxiety? I mean, I experience social anxiety from time to time.

Dr. Dave: Yeah.

Peter Kinderman: Do I have Social Anxiety Disorder? What does it mean when we add the word "Disorder"? So I think that those sorts of questions are being asked by radical, critical psychiatrists, a lot of psychologists, especially in Europe, but yes I would maintain they're

being asked in the BMJ and their editorial about DSM-5. They're also being asked by people like Tom Insel. Before Tom stepped down as the director of the National Institute for Mental Health, there was the program to develop RDoC, the Research Diagnostic Criteria, as an alternative to the standard diagnostic approaches. Why? Well because the standard diagnostic categories don't map onto biological... emerging biological findings. And that's a valid criticism. Whatever is going on for us as biological human beings, the genetics, the biochemical pathways, and the observable consequences on our mental health, don't map onto those diagnostic-disease categories. They don't make sense from a biological point of view. They don't make sense from a sociological point of view, when we apply criteria to how long we expect people to grieve before we label it as disordered. They don't make sense from an ethical point of view. When I see a veteran who's been traumatized by warfare, it makes me feel slightly uneasy to say: "Yes, there's something disordered" in him or his action. I think it's a problem, but I don't think it's a disorder. And then we move on to other issues. PTSD is a very good example. So, commonly in the UK, there's a so-called [??] about domestic violence. To what extent would a woman or a man who is being traumatized by domestic violence, to what extent is it appropriate to suggest there's a disorder? Because they're showing the understandable consequences of being exposed to domestic violence. So, yeah, absolutely, I think not only people like me are questioning the validity of applying a disease metaphor to those experiences, but I would maintain that people like editorials in the BMJ, editorials in The Lancet, Tom Insel himself criticizing RDoC, yeah all of them are saying that the common system just doesn't work.

Dr. Dave: Yeah. That certainly harkens back to Thomas Szasz whom you mentioned at the top of our interview. And it's a... I remember being very impressed by what he had to say when I was a graduate

student. And so... And at times I've wondered what happened to that? You know. Did that go away? And so it's good to hear that it hasn't gone away and that more people are revisiting it.

Peter Kinderman: I think people are revisiting it. And... But I do need to make clear that this isn't a manifesto saying that there's nothing to do with psychiatrists. I think it's something about whether these things represent disorders in the human spirit. And I think that that's why for me there's a conceptual link between this way of thinking, which is to regard us all as normal but flawed human beings, struggling to make sense of and respond to... well the only world that we've got, but undeniably a flawed world. And that means that, for me, that the idea of seeing us not as disordered, or even our responses being evidence of disorders, but as just human beings responding in our flawed and even biologically variable ways to the stresses and strains of modern life. That does, for me, fit with the idea that there's a social, political community basis to what we're doing, rather than just the medical approach. The reason why, I think, that the ideas of Thomas Szasz haven't taken hold as much as they otherwise would, is I think that there are lots of spurious beguiling benefits for people, other than the individuals experiencing distress, from the industrialization of mental health services. So it suits politicians, to say that the person is disordered and to put the problem out of mind, it suits the community in some ways to not reform the social structures that give rise to such distress but to pick up the casualties later. It's useful, I think, to regard veterans who return home from wars as having PTSD rather than to say: "What are we going to do about this scourge of modern times?". And I think also, to be blunt, I think it suits the pharmaceutical industries to market products to deal with distress rather than to demand that we, as a community of human beings, respond to each others distress.

Dr. Dave: Yeah, what you're saying triggered so many ideas in my mind, I have to try to remember them all. You know we talk about mental health patients who... there's the older concept of secondary gains that makes it hard for a person to recover from their issues because there are rewards inherent in it. So what you've just described is that the government and other entities... other huge social entities have secondary gains that make it in their interest to maybe not change things so much.

Peter Kinderman: And I need to return to something that you were saying a little bit earlier, which... I don't want to be critical but I'll pick up on it a little bit, which is when you said, you know: "The poor has always been with us". And if you can imagine...

Dr. Dave: I was playing devil's advocate, by the way (laughing).

Peter Kinderman: If you imagine both a family doctor or maybe a politician or maybe a city counsellor or a nurse or a medic working in an emergency department, and somebody comes in in acute distress. I think that the solution I'm offering is an extremely challenging one. Whereas the solution of saying: "I think you meet the criteria from mental health problem, you may therefore want to take a referral to see a psychiatrist who can prescribe medication or therapy that can help you with that problem". You've got a pathway and a solution, you've got a recognition of the problems that the individual is perceiving, recognition and understanding, and then a solution, a potential solution to their problems. The physician or the politician, or the priest or whoever has got a route forward. So, in a sense, it offers us all a beguiling quasi-solution to the person's problems. What do you do with somebody, even if you're a police officer, what do you do with a woman who is being subject to domestic violence for twenty years? And what you can do is you can do your job as a policeman and then

what do you do? Well then what you do is you say: "And I think you probably should see a doctor, you know, maybe they could help with the emotional distress that you're experiencing". And it's a very attractive solution. And I'm not suggesting that we shouldn't do that. I'm suggesting that we need to change the way that we think about it. As if those responses are actually treating an underlying illness. And I think there are best attempts to help people with a very difficult social and emotional situation, which may involve their personal, biological, vulnerabilities. But I think we need to think about it in a slightly different way.

Dr. Dave: Yeah. Not only think about it differently but also speak in language these issues differently since the two are so closely bound.

Peter Kinderman: Well, one other thing that occurs... Because like everybody, I find myself in communities of people who tend to agree with me, that's what...

Dr. Dave: (laughing) Yeah!

Peter Kinderman: I'd prefer not to but that's what happens. One of the comments that people have made is about the very well known stress-vulnerability model. And the stress-vulnerability model, especially when it comes to serious mental health problems is seen as a very inclusive way of talking about these issues. So, the person has their own vulnerabilities, some people are more vulnerable than others, some people have greater or lesser resilience, and some of us also experience greater or lesser degrees of stress in our lives. And the idea would be that if you are particularly vulnerable, it doesn't take as much stress to trigger the onset of mental health problems as for most people. And quite a few people who've experienced mental health problems are rather annoyed at the idea that instead of saying: "Let's

examine the factors that have impacted negatively on your mental health”, the message is that they should be regarded as somebody who’s vulnerable.

Dr. Dave: Hum.

Peter Kinderman: And I think that’s an interesting perspective.

Dr. Dave: It is. It is because it’s not one that I’ve heard.

Peter Kinderman: No. And what it triggered in my mind is... in law, certainly in the UK, there’s a concept that lawyers learn which is the eggshell skull rule. And it’s... it refers in UK law to an actual incident where, you know, a rather nasty incident, a one man punched another in the head, and the victim fell over, and I believe died because he fractured his skull when he hit the floor. And the charge was of murder. And the defense was that he shouldn't be charged with murder because all he did was commit a felony assault of battling, and that while the man died, the death could not be attributed to the assault, it should be attributed to the fact that he had a biological issue, that led him to have a particularly thin skull. And the outcome of this, which is reasonably well established in UK law, and actually as the judge said, had been there for many years, is that you don't get a lesser sentence if you assault a child or a little old lady or a gentleman with walking sticks struggling to pass the road. Actually, you get a worse sentence. So when it comes to the law, what you don't say is: “Individuals who have vulnerabilities differ in the degree of vulnerability” and we shouldn't regard the causal agent, the assault, as being of greater or lesser importance varying on the level of vulnerability of the victim, what we do is we prosecute people actually more seriously if they've assaulted a vulnerable victim. So when it comes to the stress-vulnerability model in schizophrenia, one of the

arguments should be: of course we come with all sorts of vulnerabilities, but if we didn't see those as biological contributors to an illness, but rather parts of the makeup of human nature, its true community of us as equals. Yes, some of us have mental disabilities, some of us have physical disabilities, some of us have speech and language problems, some of us have eye sight problems, some of us are particularly tall, some of us are physically well built, some of us have biological makeups that make us more or less vulnerable to being assaulted when being in a Newcastle bar on a Friday night, and some of us are more emotionally sensitive than others. That's how people are built. So parts of the argument is that maybe we should talk about and think about these things as being the inherent nature of the variability of human beings, rather than biological contributors to illnesses.

Dr. Dave: You know, this puts me in mind of something that I've discovered some time back, is that there may be an emerging field of clinical philosophy. And I have not interviewed a clinical philosopher yet, but it would seem to dovetail with this idea that it's got to do with problems in living.

Peter Kinderman: I think there are lots of things that follow that. I went to a seminar at the University of Oxford which is, you know, an impressive place to have a seminar, and one of the psychiatrists who was being interested in genetics pointed out that he... I think over dinner... had met a guy who had commented that he, the third party, was the son of a father who appeared to be extremely biologically vulnerable to the effect of alcohol. And this gentleman's assumption was that he may well have inherited that biological vulnerability.

Dr. Dave: Yes.

Peter Kinderman: Which is why he decided never to take alcohol. So the point there is that he's making a behavioral and cognitive choice to circumvent his biological destiny.

Dr. Dave: And... I'm not quite sure what your point is there?

Peter Kinderman: That's what we do all of the time. Now, what I mean is several things to me, which is: it means that the genetic factors that are associated with, for instance, vulnerability to problems with alcohol, are entirely plausible. And I think the role of neuroscience, the role of biological science is extremely powerful. But that doesn't necessarily mean that you therefore conclude that the only thing that you need to do about alcohol is understand the biological pathways. What you also do is decide to take a path in life which is different to the one that your genes embody for you.

Dr. Dave: Oh, Okay.

Peter Kinderman: So my point is that it's a philosophical, psychological, moral choice as well as a biological one. But it doesn't stop it being biological. So the role of medics is still here, is still great. If it's the case that some people have biological traits that make them much less able to sit still for long periods of time in classrooms, I think that's very interesting. I'm not sure that I would conclude that that means that they've got the biological traits of the disorder of Attention Deficit Hyperactivity Disorder. I think that it's wonderful that some of our kids are born that way... it may be problems too but that's the way that they're born. I think it's fantastic that some of us are much better at cycling than I am. I envy them, their ability to cycle. That's the way that we're built. So I think that thinking about these things as human traits, that bring benefits and advantages but also bring downsides and problems, and that what we need to do is piece

together the story of why a particular person is experiencing difficulties in this particular time in their lives. I think that's absolutely a biopsychosocial phenomenon. But it's not the same as diagnosing them with an illness and then treating it. And so my point is that it involves biology just as much as it involves psychology, but it still isn't necessarily the treatment of illnesses. So I was just riffing, I think off your point about clinical philosophers which is: "What does it mean to see the world or to see human actions in this way?" and I think it's interesting.

Dr. Dave: Yeah. And it's interesting also to realize with your example of hyperactivity, that some of those people go on to do fantastic things in the world. The people who couldn't pay attention in class and so on become CEOs and so on (laughing)... There are plenty of examples of that.

Peter Kinderman: Yeah. And there are all sorts of examples. I think that's stretching the issue of the creative benefits of serious mental health problems, sometimes pushing things a little bit. But I think that there are huge questions to be answered here. And one of them is whether the things that we are talking about are diseases in the sense of smallpox being a plight on the species, or whether the ability to see the world through different eyes is something that we should, as a species, be extremely grateful for. And there's a number of examples of this. One of them is that for many of the people I see as clients, as clients for psychotherapy, they seem to be people who are genuinely very sensitive. And I note that oftentimes people are talking about issues where it's difficult for them to move on in their lives emotionally because of the distress of their experience and things that have happened and that even extends to watching the television news. So people will say, you know: "I'm feeling really really upset today. I was watching the migrant crisis on TV and it just fills me with horror."

Dr. Dave: Yeah.

Peter Kinderman: And I'm sitting there and to be perfectly honest, I'm sitting listening to them and I'm thinking: "I watched it too" and then I got up half way through it and I went to make myself a cup of tea, I fed the cat, I came back, checked my emails and then carried on watching the news story". So who's the person with the disorder? The person who's emotionally touched by the distress in other people and has a negative consequence of that the next day? Or the psychopathic bastard who's sitting, listening, and goes on to make a cup of tea while watching footage of people drowning? And I'm not absolutely convinced that they've got the disorder and I haven't. And yet another example which I think is interesting is: my brother has very serious mental health problems, and I look at it as part why I became a clinical psychologist, I think. And if you gave me the sequence "A B C... : Complete the sequence", I will say "Z" because "D" doesn't complete the sequence, "D" is the next in the sequence but to complete the sequence you go all the way to "Z". And I like to think, maybe I'm over-representing the metaphor but I like to think that's the way my brain works. My students find me an engaging lecturer but also very tangential. When I do interviews like this, people will say: "He was all over the place, he was talking about clinical philosophy, he was talking about human rights, he was talking about watching the migrant crisis on TV, he was talking about philosophy and alcohol, I didn't know where Peter was coming from, that interview seemed to go all over the place". Well maybe that's what I've inherited. Maybe I've inherited a brain that tends to go all over the place. Maybe I've inherited biologically neurons that tend to support a way of thinking where my thoughts go all over the place. And you know what, I think that's possibly true. I wouldn't be surprised if it were not true. And I think that loosening of associations to go back to a phrase that Bleuler

used may well have negative consequences. I'm not always the most emotionally consistent with people in my life. But I think my vice-chancellor values that trait in me very highly. Because I'm intellectually creative, I'm intellectually spontaneous, I don't think in straight lines. And Winston Churchill incidentally used to say that he during the Second World War that he valued employing people who would think round the corners. And there are massive personal benefits to having a lively, engaging, creative, non-parallel brain. I think that's a fantastic thing to have. But maybe, whatever it is that I've inherited from my parents that gives me that sort of brain brings with it the risk that my brain will lead to emotional confusions, will have me going up on tangents, and with certain other risks and circumstances in my life that could cause me emotional damage as well. So maybe it's good to be creative, it's good to inherit creativity, but not too much.

Dr. Dave: I think that could be a great wrap up to this interview. I wonder if there's anything though that you'd like to add as we're winding down here? We could go on, I've got a couple other ideas but... I've held you for some time here.

Peter Kinderman: No, because people engaging with me in debates on blogs and so forth are frustrated by some of the things I say. I think that I want to say two things about the role of the brain as a physical organ and the role of doctors, medics, psychiatrists. And I suppose my point would be: I'm not stupidly naive to think that the organ with which I think is not the brain. I am aware that all of what I talk about in terms of our emotional and intellectual response to the events in our lives involves the functioning of the brain. And I think that it is obvious that genetic biological and other physical factors impact on my brain. Of course they do. So my brain is influenced by all of this, my brain is the product of my genes, and my brain is the

product of the biological substrate of my brain. And that's true when I'm writing poetry, which I adore to do. It's true if I were into street drugs, it would affect the functioning of my brain. But my point is that that biological root affects our mental health when it affects the way in which our brain makes sense of the world. So I don't deny, at all, biological elements in our mental health. My point is that it's fundamentally a social and psychological phenomenon that we're looking at, where the brain plays its part in that process. But the brain is literally an organ, it serves a function for us, rather than being a be-all and end-all final determinant of our behavior. So, if you put me on a diet that reduces the amount of tryptophan in my body, tryptophan is a precursor of serotonin and it will have an effect on my mood, of course it will. And as the tryptophan in my system is exhausted, and my body may find it difficult to manufacture serotonin, that will have an effect on my brain, it will have an effect on my nervous system, and it will have an effect on my mood. Because it will start to change the way that I think about the world. But it's how I think about the world that's important. And if I take antidepressants, again it will change my mood, it will change my thinking, it will change the way that I look at the world. But it's how we make sense of the world that's important. So, for me, I'm not denying a biological element in this, and I'm absolutely not denying the role of colleagues from a psychiatric profession in helping people with mental health problems. I suppose what I'm saying is that the metaphor of talking about disease is only one of a number of metaphors that we could use to describe the relationship between events in the world, our body, and the consequences in terms of how we think and how we feel and how we act. And to sort of misquote Eric Kandel: "Given every psychological process, even the most complex involves synaptic changes at the level of the brain". Then, by that logic, we should diagnose voting for a right wing politician, one of these that we discussed at the beginning of this...

Dr. Dave: Yeah.

Peter Kinderman: ... being a brain disease. We don't. It's a complex human response that like every other response we make involves the brain. So it's just the metaphor of regarding this as illnesses and diseases that I think is the point that I want to draw out. What we're doing is making sense of the world, there's a variety of influences in how we make sense of the world. And then when we help people, what we do is try to understand what those influences have been, what the conclusions are, and then how the person match that part out of the difficulties that they find themselves in. And I think the disease metaphor is only one of possible metaphors and I think it has a lot of flaws to it.

Dr. Dave: Okay. Well, if nothing else, you've underscored how complex the factors are that result in the problems of living that we deal with, and there is not... a simplistic approach isn't gonna work. So I really want to thank you for sharing yourself and your ideas here and helping to re-enliven this debate that's been with us for some time. So Dr Peter Kinderman I want to thank you for being my guest today on ShrinkRapRadio.

Peter Kinderman: And I apologize for the convoluted nature of my thought processes, all I can do it blame my brain for it!

Dr. Dave: (laughs)

Dr Kinderman is a blogger for Scientific American. We didn't get around to discussing what I thought was a very interesting point in one of his recent postings there. He raises the oft quoted idea that the disease model takes the burden off the therapy client by suggesting

it's not their fault anymore than a broken leg is. Here's how he puts it. In the subsection he's titled "Stigma and empathy", he writes: "Traditionally, the idea that mental health problems are illnesses like any other, and that therefore people should not be blamed or held responsible for their difficulties has been seen as a powerful tool to reduce stigma and discrimination." He goes on to say: "Unfortunately, the emphasis on biological explanations for mental health problems may not help matters because it presents problems as a fundamental heritable and immutable part of the individual. In contrast, a more genuinely empathic approach would be to understand how we all respond emotionally to life's challenges". I had planned to put another somewhat challenging question to him but we ran out of time. I wanted to get his take on recent developments in neurofeedback in which the practitioner targets specific areas of the brain, depending upon the diagnosis to either up regulate or down regulate activity in that area as is appropriate for the condition. I remember one of my guests in particular reporting very good results. Specifically I'm recalling episode #452 "Neurofeedback in The Treatment of Developmental Trauma" with Sebern Fisher M.A. I would have been interested to hear his comments on this. I certainly do agree with Dr Kinderman that the social and political environment play a very large role in shaping our brains, and that the negative experiences in that realm are major contributors to what we've called psychopathology. Dr Kinderman has a new book on this topic. The book is titled "A Prescription for Psychiatry". In it he offers a manifesto for mental health and wellbeing. And not surprisingly, he argues mental health services should be based on the premise that the origins of distress are largely social. Once again, let me encourage you to purchase his book using our Amazon.com widget in the right end side bar on ShrinkRapRadio.com