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EDITED BY KIRIACKOS XENITIDIS and COLIN CAMPBELL

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Ethical framework in clinical psychiatry

Bloch & Green (2006) provide an excellent overview of the ethical issues that are encountered in clinical psychiatry and the different available frameworks for understanding and resolving them. What is striking, however, is that this discourse is almost entirely without reference to God or religion.

Such pragmatic atheism is, of course, not at all unusual these days. It is a reflection of the impact of the Enlightenment upon our understanding of the way in which public discourse on such matters should be conducted. Indeed, there are even avowedly religious writers (such as Bishop Richard Holloway) who consider that it is unhelpful to bring God into such debates (Holloway, 2000). However, it is still remarkable that an entire article of this kind fails even to mention the matter.

It is remarkable, for example, that the important historical influence of Judaeco-Christian ethical thinking upon the culture in which we live is apparently entirely ignored. It is equally remarkable that the religious pluralism of contemporary Western culture is not addressed.

The omission is remarkable also because religious belief and belonging to a faith community have such important influences upon the ethical thinking of both those who suffer from mental disorders and those who care for them. To imagine that ethical conversation can be had while entirely ignoring such influences makes it feel as though atheism is being imposed upon the debate. The omission is also remarkable because of the validity of at least some of the arguments of Richard Holloway and others with respect to the dangers of bringing God into the conversation. When we feel that we have God 'on our side', human beings can become very intransigent, ungenerous or even unreasoning. The need to understand how and why this is the case is therefore very important.

The omission is also remarkable, however, because it avoids discussion of the possibility of a point of reference for both rule-based and character-based ethics which might actually transcend that of the human parties involved. Again, I recognise that there are those who will deny that such a point of reference exists – but surely the discussion about whether or not it exists, its potential impact and the plurality of views about its existence is rather important.

Declaration of interest

C.C.H.C. is an ordained Anglican priest and a part-time employee of St Antony’s Priory, an ecumenical spirituality project in Durham.


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Bloch & Green are to be congratulated for their lucid and helpful paper, which deserves to be read widely. The progression from Kant to the ‘ethics of care’ seems similar to that from the Old Testament rules/laws/commandments to the New Testament injunction of Christ that people love one another, consonant in turn with the recommendations of other faith traditions about developing wisdom and compassion together.

Bloch & Green’s paper resonates with my sense that, as professional caregivers, we do well to acknowledge our own journeys towards personal, moral and spiritual maturity, as described by James Fowler (1981), who draws on both Erik Erikson and Lawrence Kohlberg. Dilemmas such as that described in the vignette offer people opportunities to grow wiser. Grieving losses occasioned by our limitations on the way, we may develop an incremental degree of emotional equanimity, enabling more detached observation and closer engagement.

By staying calm in difficult situations, we foster the trust of others, which is paramount in encouraging people at least to share – and sometimes with relief to relinquish – decision-making and control. Authority comes not only from a professional role and medico-legal powers, but crucially also through a competent, composed and thereby reassuring personal demeanour.

The subjectivity involved should not require an apology. On the contrary, it is essential in allowing us properly and privately to reflect later on our part in what has occurred. This aspect deserves greater emphasis in medical and psychiatric education; for it is not at the heart of why we choose our profession? We want to be good people as well as good doctors, and passing exams is only the half of it.

I disagree, therefore, with the authors’ comment, ‘Nothing extraordinary is required of [the doctor]’. Consistently selfless devotion to the well-being of others is, sadly, well outside the ordinary these days; but it is exactly what we might choose to ask of ourselves if we are to get the fullest satisfaction from our professional lives. An ethical framework such as Bloch & Green have generously provided is welcome, but they are surely telling us that protocols alone will simply not be enough.

Declaration of interest

L.C. is on the executive committee of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists. He is the author of Love, Healing and Happiness: Spiritual Wisdom for the Post-Secular Era, which is to be published in 2006 by John Hunt.


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Medical ethics is in crisis and psychiatry is not exempt. This is so because the pluralism of contemporary democratic society
I found the philosophical discussions of Bloch & Green (2006) interesting, without necessarily revealing anything new. However, I was deeply concerned by the case used as an illustration. It appeared to reflect a rather paternalistic, single-professional, single-agency approach to child protection. Clinically this perspective can lead to serious mistakes. As named doctor for child protection for the Leicestershire Partnership NHS Trust I train other staff to seek advice from me and from the named nurse. There was no mention by Bloch & Green of statutory duties of care to the child. The fundamental principle of paramountcy was not mentioned. It was identified that with a mother with psychosis there was a significant risk of harm to the young child. Once this is identified, the children’s social services department should be notified (Department of Health, 1999), and should take the lead role in carrying out Section 47 child protection enquiries. All agencies have a duty to assist in collating and sharing all relevant information, to update on the situation and assist in monitoring the child and providing additional support. Reder et al (1993) give many examples where information is known to one or two individuals in single agencies who fail to share it, resulting in the omission of any child protection plan. If anything seriously untoward were to happen to the baby, a thorough case review would be undertaken by the area child protection committee/local safeguarding board and a doctor could potentially be found negligent for failing to carry out child protection procedures. I wonder whether this highlights the need for many doctors to update their child protection training?


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Job satisfaction of mental health social workers

Evans et al (2006) address major issues concerning mental health social workers, who are an important part of the multidisciplinary team. Although a remarkable paper, I would like to raise a few points regarding the methodology.

First, a single-item rating scale was used to measure job satisfaction, which I consider a multidimensional construct. It can be influenced by a variety of factors and should have been measured using scales such as the Job Descriptive Index (JDI; Balzer et al, 1997) or the Warr–Cook–Wall scale (Warr et al, 1979). The JDI assesses the amount of work in the job, current pay, opportunities for promotion, supervision and co-workers. The Warr–Cook–Wall questionnaire covers overall job satisfaction and satisfaction with nine aspects of work, each rated on a seven-point Likert scale with higher scores representing greater satisfaction.

Second, there is no mention of the reliability or validity of scales used to measure burnout and job satisfaction. In addition, the adjusted response rate is only 49% and the profile of non-responders is not included to clarify responder bias. Moreover, stepwise multiple regression would have been more useful than linear regression to investigate the relationship between several independent variables and a dependent variable.

Notwithstanding these limitations, this paper should be an eye-opener to employers regarding the needs of mental health social workers.


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Authors’ reply: We agree that job satisfaction is a multidimensional construct, and we measured several features of
job-related satisfaction in addition to satisfaction with one’s job itself. Although the measures suggested by Dr Kader would have been appropriate, some of their items overlapped with the Karasek Job Content Questionnaire (Karasek, 1979), and we were keen to avoid such duplication and overbundenning respondents. As we were interested in the relationship between satisfaction with one’s job and other indicators of job-related satisfaction such as feelings about pay, operational and policy contexts (which were and remain topical because of proposed changes to the Mental Health Act 1983) and feeling valued, it would have been inappropriate to use a multi-faceted job satisfaction scale as a dependent variable. All of the scales used in the survey are well known and have established reliability and validity.

The adjusted response rate of 49%, although low in comparison with experimental studies, is very reasonable for social surveys of this type. We agree that it would have been helpful to know how non-respondents compared with respondents in terms of demographic and other details, but the methodology meant that was not achievable. Nevertheless, do know that our sample was very similar, demographically and in terms of tenure, length of experience, approved social worker status, etc., to another recent study of mental health social workers (ADSS Cymru, 2003). Therefore we have no reason to believe that these data are not representative.

Finally, although it might have been interesting to present a stepwise regression model, we opted for an ‘enter’ model in the interests of brevity. Subsequent analyses have shown that a stepwise approach offers little added value.

Like Dr Kader, we hope that the results of our survey are an eye-opener for employers.


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Psychological factors in bipolar disorder

Jones et al (2005) have focused on the important although relatively neglected area of psychosocial aspects/intervention in bipolar affective disorder. Although there are several previous reports on the subject by the same group, this study has a better design and a much larger sample size. However, some central issues remain unresolved.

The authors were unable to find dysfunctional beliefs specific to bipolar disorder. Cognitive therapy as practised in depressive or panic disorders attempts to correct characteristic dysfunctional beliefs (Beck & Rush, 2000). In the absence of a specific pattern of dysfunctional beliefs, devising effective and specific cognitive strategies to treat bipolar disorder may be difficult. This is illustrated by the pilot study of cognitive therapy in bipolar disorders by the same group (Scott et al, 2001) in which relatively non-specific strategies such as self-management of symptoms, dealing with non-adherence, an-terlapse techniques, etc. were employed. The lack of precise techniques could also have resulted in the differential efficacy of cognitive therapy, with effects mainly on depression, rather than manic symptoms.

In the current study Jones et al used a 24-item sub-scale version of the Dysfunctional Attitude Scale, whereas in earlier studies (Scott et al, 2000; Scott & Pope, 2003) a 40-item scale was used. It is not clear whether the use of different versions of this scale contributed to the ambiguous nature of the dysfunctional beliefs found in bipolar disorder, especially since the two different versions appear to have different sub-scales. Finally, although some potential confounding variables, such as current mental state, were controlled for, others, such as duration of illness, severity, chronicity and possible effects of pharmacoprophylaxis, were not. Cognitive style may vary according to these factors (Scott & Pope, 2003) making it necessary to control for them.

It is possible that these concerns will be addressed by future research. This study paves the way for examination of psychosocial factors in bipolar disorder.


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Authors’ reply: We are pleased that Biswas & Chakrabarti highlight the strengths of our study design and large sample size, and consider our work a significant contribution to understanding psychological factors in bipolar disorder. We agree that it is important to consider potential confounders and therefore examined the effects of differences in illness duration and severity. Although there were some differences between our two patient groups on measures of illness severity and a small number of modest correlations between illness severity and cognitive style, covarying for these measures had no effect on our finding that those with bipolar disorder have fragile self-esteem and dysfunctional beliefs similar to those of people with unipolar disorder. We have not been able to examine the possible effects of pharmacoprophylaxis on cognitive style, but agree that this could be a target for future research.

We do not think we would have found differences in cognitive style between participants with bipolar and unipolar disorder if we had used a longer version of the Dysfunctional Attitudes Scale (DAS). The 24-item version used in our study was factor-analytically derived from the longer version and has improved robustness (Power et al, 1994). The ‘need for achievement’ and ‘dependency’ sub-scales of the 24-item DAS comprise items from the ‘perfectionism’ and ‘need for approval’ sub-scales of the 40-item DAS respectively.

We hope that future studies of cognitive style in people with mood disorder will build on the strengths of our study by using


prospective longitudinal designs, systemati-
cally ascertained samples and perhaps
implicit measures which cover other
potentially interesting and clinically rele-
vant cognitive traits such as goal attain-
ment, attributions, self-representations and
novelty-seeking.

Dysfunctional Attitudes Scale (DAS): a comparison of
forms A and B and proposal for a new sub-scaled

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What is pathological lying?
The article by Yang et al (2005) is provoca-
tive, thoughtful and intriguing and provided
much food for thought. Participants were
divided into three groups: liars, normal con-
trols and antisocial controls. Half of those
in the liars group were malingerers and
the others displayed conning/manipulative
behaviour on the Psychopathy Checklist –
Revised (PCL–R), deceitfulness criteria for
DSM–IV antisocial personality disorders
or pathological lying as defined in the
PCL–R. Yang et al referred to pathological
liars specifically in the title of their paper
but we are concerned that the definition
of liars was so broad and wondered
whether the article would not have been
to be considered as a defined pathological liar'.
The authors included individuals
with different lying characteristics in
a group of pathological liars and this is
problematic.

Our recent review (Dike et al, 2005)
showed that the term ‘pathological lying'
was used differently in the literature
from how it was used by Yang et al. Patho-
logical lying is distinct from malingered or
the other forms of lying exhibited by those
included by Yang et al in the liars group.
We defined pathological lying as falsifi-
cation entirely disproportionate to any dis-
cernible end in view, may be extensive and
very complicated, and may manifest over a
period of years or even a lifetime’. Patho-
logical lying is a repetitive pattern of lying for
which an external reason (such as financial
gain) often appears absent, and the psy-
chological basis is often unclear. This
definition has not been accepted by the psy-
chiatric community but summarises the
elements of pathological lying. Inter-
estingly, we found that pathological lying
can also be found among successful indi-
viduals without a history of criminal
behaviour.

We commend Yang et al for investigat-
ing the neurobiological basis of lying.
Whether the prefrontal white matter changes
indicate a causal relationship with
lying or just an association is unknown.
However, pathological lying per se was
not specifically investigated, as suggested.

Pathological lying revisited. Journal of the American
Academy of Psychiatry and the Law, 33, 342–349.

white matter in pathological liars. British Journal of
Psychiatry, 187, 320–325.

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Authors’ reply: We wholeheartedly agree
with Dike et al that the definition of ‘patho-
logical liar’ is vague and confusing.
Although pathological lying has been
defined in several different ways, no speci-
fic psychological test is available. Hence
we applied a symptom-based approach
and defined individuals as ‘liars’ if they ful-
filled: (a) criteria for pathological lying
on the Psychopathy Checklist – Revised
(PCL–R), (b) criteria for conning/manipula-
tive behaviour on the PCL–R, (c) the decei-
tfulness criterion for DSM–IV, or (d) criteria
for malingered as reported in a self-report
crime interview.

We maintain that our study did inves-
tigate at least one form of pathological
lying. In a new analysis, we found that
42% of our liars had psychopathy, anti-
social personality disorders or borderline
personality disorder. These liars likely
correspond to those Healy & Healy
(1926) refer to as ‘secondary pathological
liars’ – people whose lying is a complica-
tion of disorders such as those above.
The other 58% of our group, who did not
meet this comorbid requirement, prob-
able correspond to the ‘primary pathologi-
cal liars’ described by Healy & Healy –
people who habitually lie but do not
demonstrate symptoms of a clearly defined
psychiatric disorder. This new analysis
also revealed that liars with or without
psychiatric disorders showed significantly
increased prefrontal white matter volume
compared with antisocial controls
(P<0.003, P<0.01, two-tailed respec-
tively) and normal controls (P=0.005,
P=0.014 respectively). Although our study
is a preliminary attempt to reveal brain ab-
normalities in people who lie, cheat and
deceive we hope that it will stimulate in-
terest in this important but understudied
phenomenon.

Healy, W. & Healy, M. T. (1926) Pathological lying,

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