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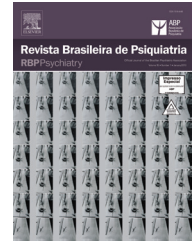
SPECIAL ARTICLE

The history and development of Australia's Black Dog Institute

Gordon Parker[1,2]

[1]School of Psychiatry, University of New South Wales, Australia
[2]Black Dog Institute, Sydney, Australia

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Abstract

Objective: To overview the development of the Sydney-based Black Dog Institute. *Methods:* The strengths and limitations of the Institute's predecessor (the Mood Disorders Unit) gave way to a more ambitious Black Dog Institute, and this article gives an overview of the Institute's structural and functional components. *Results:* It is argued that the Institute serves as a model for modern psychiatric service delivery. *Conclusions:* The Institute's model of linking clinical, research, education and community activities to advance the understanding, diagnosis and management of mood disorders is detailed for wider consideration.

Introduction

In the 1980s, when I was appointed head of a university department of psychiatry and its associated hospital services, I elected to modularize the academic bases across several clinically defined domains, including schizophrenia, anxiety, neuropsychiatry and mood disorders. The last domain involved establishing the Mood Disorders Unit (MDU) at one of Sydney's principal teaching hospitals, with both in-patient (15 beds) and out-patient facilities. The management model for the overall enterprise was an iterative clinical research paradigm in that our clinical observations shaped many of our research studies, with subsequent research findings then shaping our clinical approaches. The clinical needs of referred patients (who sought a more precise diagnosis as well as management recommendations) were prioritized above our research objectives. This priority both met their needs and avoided any concern that they might feel like research guinea pigs.

Such prioritizing did not, however, prevent us from obtaining a large amount of standardized data from patients about their mood disorder at the time of presentation and at relevant follow-up periods. In essence, patients appreciated their clinical assessments and were thus keen to assist us by generally being highly conscientious in providing us with data for our differing studies, thereby increasing the validity of the data.

Our research approach for the first decade weighted a trunk and branch model where we, as a group of clinician researchers, had a set of truncal activities that united us all in a collaborative enterprise (e.g., how best to differentiate melancholic from non-melancholic depression), while each

of us also had our own branch studies (whether pursuing the utility of a biological test, a particular etiological factor, a social hypothesis or other research nuance).

The positive evaluation of our clinical service by patients advanced support from our state health department and our hospital administrators, while the significant research output (especially translational research) advanced our success in obtaining competitive research grant funds. However, after 15 years, the MDU (essentially a tertiary referral service) had assessed only approximately 2,000 patients. I judged that it was time to consider an alternative and more ambitious model, one that would assist a greater number of people.

Although most of our team had university and hospital appointments, I favored establishing a stand-alone institute facility that would be independent of both systems (and less constrained by their necessary processes). This institute would have its own independent board and executive team managing the enterprise, although links would be established with appropriate universities, hospitals and other institutions. I invited a board chairman, who progressively selected and accrued board members from industry, health, business, law, the arts and the general community as well as consumer representation. The institute's patron is the governor of New South Wales and a psychiatrist, Professor Marie Bashir.

One of first tasks was to determine a name for the institute. Although I personally preferred Mood Disorders Institute, several Board members viewed such a name as sterile and uninspiring, immediately demonstrating the wisdom of having Board members outside of the medical/psychiatric world. One suggested The Black Dog Institute, capturing Winston Churchill's descriptions of his own depressive states as a black dog. Most of us were initially ambivalent about the suggested name but progressively warmed to it and so proceeded with its naming.

Prior to the Institute being established, there had rarely been any reference to the black dog in the media. In 2002 - the year that the Institute was established - the only media references to black dog were in regard to the Institute itself. Subsequently, the term was rapidly taken up by the media. When a politician or a sporting star was struck down by depression, the story heading would generally replace the word depression with black dog. (e.g., Black Dog bites politician or Time to lose stigma that trails Black Dog). The black dog metaphor resonated with greater gravitas than the word depression, and its progressive adoption across all media outlets was not only a distinct advantage to the new institute in making itself rapidly known but also an advantage in advancing the general destigmatization of mood disorders. Thus, the naming of the Institute was of fundamental importance – creating intrigue and sparking interest.

It is commonly asked whether Churchill coined the phrase black dog. To resolve this issue, we undertook an essay competition to determine the phrase's history and subsequently published a book summarizing material from those essays.[1] In essence, the phrase did not originate with Churchill, but being a respected historian, he was aware of Samuel Johnson and James Boswell describing and writing about their own depression as a black dog, and he borrowed from their descriptions. However, the phrase's history goes back to very ancient times. Celtic people would describe a black dog or a black fog, and there are references by Horace to the black dog. Even references by Plutarch around 450 BC have been found. As one of our essayists (Megan McKinlay) wrote, it is clear that the metaphor Black Dog was not Churchill's but rather an image whose history extends back to classical mythology and which endures in a range of forms as a consequence of literary, folkloric, psychological and linguistic factors. McKinlay observed that the term most likely had no single point of origin and that there was no tidy trail of evidence that could be followed in a satisfying linear fashion; instead, the term may have evolved in a rather complex and multi-layered manner. McKinlay did, however, accept that the image belonged to Churchill in that he revived the phrase; because of "who Churchill was", the phrase has evolved into the symbol we have today. McKinlay concluded that it is against Churchill's "own personal history that it takes on its contemporary dimensions, re-configuring depression as something from which one can separate oneself, something to be named, lived with, transcended" [pp 190-191].

We had a name for the Institute that bestowed a history and an evocative image. The next task was to develop a logo. We turned to the Sydney advertising guru, John Bevins, and invited him to develop a concept and a logo. We imagined how he might represent a black dog – would it be affectionate, or would it be a fierce, feisty and ferocious image like the Hound of the Baskervilles? Instead of a dog, Bevins produced a background shadow of a dog, with the shadow created by a hand in the foreground clenched in a V for victory position that captured Winston Churchill's evocative image over the years of the Second World War. In his concept design, Bevins stated that the logo referred to and respected Churchill's terminology for depression as a black dog. His image sought to highlight a victory sign that, enigmatically, casts a shadow of a black dog and so provides a metaphor for a disorder that is constantly lurking in the background. The logo acknowledges that depression indeed shadows the sufferer, even when the mood is upbeat and victorious. Just as Churchill's sign proved stronger than the evil it opposed, the logo carries the suggestion that the positive is more powerful than the negative. Victor (victory), not victim, is the implicit hope lying in the image – but unstated to avoid the alienating suggestion of "pull yourself out of it". By neither trivializing the black dog nor turning it into a vicious monster, the concept walks an essential fine line. The logo does not seek to fight depression with depressing imagery, nor does it seek to create a saccharine symbol, while also avoiding obvious dog clichés. For those aware of Churchill's famous salute, it provided a talking point. For a younger audience who might not be aware of its history, it was designed to work as a stand-alone symbol that was intriguing and memorable and that might invite them to question its origins. The logo and concept were so evocative and successful that John Bevins was awarded a Mobius award in Chicago a year later for the concept.

Our next step was to obtain funds and build a purpose-designed stand-alone facility. The options of renting and being part of a larger institute were rejected because we judged that both risked an uncertain future or risked us being subsumed within a larger organization and not developing our own identity. We obtained funds from the NSW State Government and from a number of donors and

hired an architect (Julius Bokor) who brought great vision to the building. The building is modern, light and has blades on the roof that draw people's eyes up almost immediately after they walk into the building. Even depressed patients openly comment about how "light, uplifting and serene" the building appears to them. This design was not only intrinsically important but also served as a model for conceptualizing how psychiatric facilities should be designed – in sharp contrast to those that have an institutional ambience. The general ambience of the building is further enriched by having a series of artwork (principally paintings and photographs, the latter mainly retained from a photographic competition that we ran for people to snap the black dog) and with most capturing aspects of mood disorders and of resilience.

While the Institute sought to provide both substance and style, the latter has remained an important component. Shortly after establishing the Institute, I met the New Zealand writer, photographer, artist and former senior advertising executive Matthew Johnstone after he moved to Sydney. Johnstone had written a book titled "I had a Black Dog"[2] (independent of our Institute naming) and asked if I could write the forward to a "visual articulation" of what it is like to suffer depression and what it had been like for him. In less than three dozen cartoons, Matthew captured the mood components, the personal fallout and collateral damage and the physicality of clinical depression. He neutralized the demonic black dog by drawing on dogs countervailing image of faithfulness. He encouraged the reader to face the dog, strip it of its bite and bring it down to size. His images were whimsical and, at the end, inspiringly positive. His book was republished in the UK and became a best seller with nearly 200,000 copies now sold. A few years later, we appointed Matthew to the Institute as our DoGI (Director of Good Ideas) and now Creative Director. In addition to producing a number of books and accepting numerous speaking invitations, Matthew provides our book covers, Institute posters and enriches our professional and community educational material, ever providing strikingly positive imagery.

An early priority was to develop our diagnostic and management clinical model and, secondarily, our operational model. I have long held concerns about the sterility and low utility of dimensional models of the depressive disorders (e.g., major versus minor, severe versus moderate versus mild). I argue for a sub-typing model that positions several mood disorders as categorical and not defined by severity (e.g., psychotic depression, melancholic depression, bipolar disorder) and differentiates them from a set of non-melancholic disorders, reflecting the impact of life event stresses and personality style (and which do vary by the severity of those factors and of the depression itself). The term sub-typing is not immediately understood by many. In essence, it argues for differing types, as occurs in medicine (e.g., Type I and Type II diabetes, Hepatitis A and Hepatitis B). It also reflects psychiatric practice and its weighting to a formulation, where the clinician assigns the relative causal contribution of biological, psychological and social factors and what treatment paradigm (e.g., drug or non-drug) might best address such identified – and prioritized – factors.

A second sub-typing priority was to advance the distinction of bipolar disorders from unipolar conditions and, in particular, to argue the importance of identifying bipolar II disorder, reflecting its higher prevalence than bipolar I disorder and the greater difficulty that it provides for clinicians in terms of detection and management.

The organizational model was an extension of our earlier clinician-researcher MDU model – from two to four nodes initially. In addition to research and clinical services, we added professional education and community nodes. Each of those four nodes will be briefly overviewed.

Clinical services

The Institute established a Depression Clinic to which patients living in the state of NSW could be referred by their managing general practitioner or psychiatrist for a clinical assessment that prioritized diagnostic clarification (i.e., mood disorder or not, and if a mood disorder, the principal sub-type), a formulation and management recommendations for the referring physician. Institute procedures were established to ensure that patients attending the Clinic would find it a welcoming and constructive experience. To that end, they are warmly greeted by reception staff, and the Clinic provides recently published magazines as well as tea, coffee, water and biscuits. Patients are encouraged to take Fact Sheets and other information from the Clinic's library stands. Patients are offered a three-month review to assess progress and determine whether further recommendations might be required. The Institute also employs senior clinical psychologists to assist the management of some patients as well as to generate and deliver educational programs.

As part of the pre-clinic assessment process, patients complete a Mood Assessment Program (MAP).[3] The MAP is designed to collect relevant data from those with a mood disorder and then generate a report that allows the receiving clinician to better derive a formulation by obtaining a likely primary diagnosis as well as likely contributing factors. In addition providing key diagnostic probabilities (e.g., bipolar versus unipolar disorder, melancholic versus non-melancholic depression), the MAP is accompanied by succinct treatment guidelines developed from our clinical research evaluations over the last three decades. Initially, MAP input data required patients attending a center (established at the Institute and at several medical centers in Sydney and in rural NSW) to obtain access to a dedicated computer. Now, patients can input their MAP data via the internet, and a printed report is then sent to their referring doctor within three days. The MAP report contains socio-demographic details, details on the onset of their depressive condition, their condition's current level of severity and degree of impairment, and all current depressive features and (via an algorithm) indicates the probability of the patient having a melancholic or non-melancholic depressive condition (with an overall classification rate of approximately 80%). In addition, another set of input data allows an algorithm to decide whether the patient is likely to have a bipolar or unipolar condition, and the overall classification of such decisions is also on the order of 80%. The MAP report states whether the patient has had a lifetime and/or current anxiety condition and provides a personality profile

weighted to those personality styles that are most likely to contribute to a non-melancholic depressive disorder. Proxy measures of a personality disorder (assessed via quantifying levels of cooperativeness and effectiveness) provide information about the probability of disordered personality functioning.

The MAP also collects and provides information on any relevant medical condition, whether illicit drug or alcohol problems are relevant, and identifies major stressors (both lifetime stressors and ones over the preceding twelve months) that might have precipitated or added to the patient's current depressive condition. In addition, all drug and non-drug strategies that have been trialed by the patient are quantified in terms of their level of benefit and whether they had to be discontinued because of any side-effects. The essential design objective of the MAP was to capture the accreted clinical wisdom of our clinician/researchers who have developed the sub-typing model over the last two decades and to provide principal diagnostic probabilities (via research-based algorithms) to the referring practitioner. One of the great advantages of the MAP – and not fully appreciated by me initially – is that it actually saves some 20%-40% of assessment time by the clinician. The MAP has now been completed by more than 15,000 patients, with aligned research studies modifying its diagnostic algorithms as required.

Research

Clinic attendees are commonly first assessed by a research assistant who administers a structured diagnostic measure (including the generation of DSM-IV diagnoses) and several other research-based questionnaires. Patients are then interviewed by a clinician, with the clinician also collecting some research information. Approximately one-quarter of the patients then present to a senior psychiatrist, who interviews them to pursue and clarify both management and diagnostic issues. A debriefing session with the interviewing psychiatrist follows, and it is the Institute's key philosophy that all patients should leave the building feeling positive about the clinical interview, whether it is in relation to receiving diagnostic and management information and/or receiving an optimistic prognosis.

Research activities continue to operate using a trunk and branch model, although truncal activities have clearly changed over time, but early priorities (e.g., differentiating melancholic and non-melancholic depression, differentiating bipolar from unipolar disorder and differentiating bipolar I and bipolar II disorders) continue. The large number of patients attending clinics and completing diagnostic measures via our website has allowed us to move to more translational research. For example, of those attending the Clinic, we evaluate how they fare at a three-month review and seek to quantify the treatment factors that have contributed to their improvement or to any lack of progress. Another example is an evaluation – for those who complete our web-based self-report diagnostic measure of bipolar disorder – of the percentage who accept our recommendations for confirmation of the diagnosis and, if so confirmed, to what degree their outcome is improved and the likely

contributing factors. In such studies, we now have hundreds – and often thousands – of individuals generating information for research evaluation. Annual reports are readily available from the Black Dog Institute website and provide details on the rich research domains pursuing etiology, phenomenology, naturalistic and treatment-shaped outcome, treatment prediction and other studies.

Professional education

A professional education team prepares in-depth training material and organizes educational meetings for general practitioners, psychologists, social workers, nurses and other professionals, focusing particularly on the sub-typing model to advance more precise diagnoses and more sophisticated management for the differing depressive disorders. Very large numbers of professionals take part in such training programs, held both within the Institute and around Australia. As an extension, the Institute established a Developing Countries Program where, each year, a group of mental health and generic health practitioners are brought from the Pacific island region and developing countries and are trained in the Black Dog model, focusing particularly on management and general population strategies. The Institute remains in contact with them following their return to their country and encourages them to implement some Institute component (perhaps a fact sheet, a screening measure, or a component from our website) in their own region and to evaluate its utility.

Community

The Institute's community staff provides services from the building and in the broader community. The Community Centre receives a large number of requests for information and support via the phone, e-mail and other sources and is also a walk-in facility where people can come for information, borrow books from the Institute's library or attend support groups run by staff and trained volunteers. Staff provides educational programs to community meetings and particularly in workplace environments to destigmatize mood disorders, encourage awareness and knowledge and detail the Institute's sub-typing model.

The Institute immediately established a website that is constantly evolving. The Institute has sites for professionals, patients, families and the public. The site is rich in information, with such information again weighted to the Institute's sub-typing model. The site provides a number of screening measures for both depression and bipolar disorder. The bipolar screening measure is now completed by some 40,000 people per month and has an overall accuracy of approximately 80%. Perhaps even more importantly, and as noted earlier, we have evaluated the impact of the screen. By following a group of people who had never previously received a diagnosis of a bipolar disorder, but who were informed following screening about such a likelihood, had the diagnosis confirmed and implemented a bipolar management plan, we have been able to demonstrate that their trajectory was improved dramatically and identify the principal management components contributing to their improved

outcome. Such examples illustrate how the Institute is able to impact very large numbers of people in the general population compared to its early Mood Disorder Unit predecessor.

The information on the website is sophisticated and practical. For example, there is an 80-minute education program on the bipolar disorders with eight modules provided by ten professionals (of whom four have a bipolar disorder themselves). A published review[4] several years ago established that our bipolar website information was rated as the most sophisticated and helpful information source compared to all other international websites detailing information on bipolar disorder. The website has a number of downloadable Fact Sheets that cover predictable information about the depressive and bipolar disorders but also address narrower and quite specialized topics, such as the safety of antidepressant medication in pregnancy and what might characterize a Lamotrigine-induced rash. Readers of this article are encouraged to go to the website to evaluate its richness and depth of information (www.blackdoginstitute. org.au).

A few years ago, we established a second website for adolescents (Bite Back). It is structured to be compatible with how adolescents operate and communicate and is also best appreciated by having readers examine the site (www. biteback.org.au). In addition to information about mood disorders, the site touches on other issues that may affect adolescents, including sexuality, self-harm and anxiety. Visitors are able to quantify their psychological parameters and happiness levels, and aspects of positive psychology such as mindfulness, developing resilience and gratitude are incorporated. Most content is interactive, and visitors can tell their story and join in a supportive conversation with other visitors seeking to address the loneliness and alienation experienced by adolescents.

As an extension of professional and community education, we have published a large number of books. Many have emerged from our annual Writing Competitions where we invite people to address a particular topic. The first was on the origin of the term Black Dog and, as noted earlier, resulted in our first book.[1] Subsequent competitions have addressed factors contributing to the successful management of depression,[5] bipolar disorder,[6] teenage depression,[7] managing depression at work,[8] depression in older people,[9] post-natal depression (in preparation) and how families and friends can support those with a mood disorder (in preparation). For each Writing Competition, we receive 100-800 entries, and the resulting books seek to amalgamate excerpts from those essays and excerpts by us as mental health professionals. In essence, we seek to meld inside out views of those who have had to deal with a mood disorder with the outside in views of professionals. Although I have acquired considerable information about mood disorders from journal articles, books and professional meetings over decades of professional education, my knowledge base has expanded considerably by reading the views of those articulate and intelligent essayists who inform us about what has worked for them. Although they may not reject standard strategies such as antidepressant drugs, they see standard strategies as simply foundational agents, viewing any mastery they have acquired as a consequence of developing their own philosophy to the mood disorder, focusing on their own

wellbeing and essentially controlling their destiny. Thus, they prioritize cutting out negativity in their life, appreciating the days when the sky is blue and engaging in de-stressing activities such as relaxation therapy and yoga and engaging in exercise programs. Their information base is deceptively important, and although these books have been designed to be read by those with a mood disorder and their families, they are strongly appreciated by general practitioners and mental health professionals. Their prioritizing of factors contributing to a better outcome informs us that chronic illness is best managed pluralistically and as a team effort rather than as a hierarchical model where the professional dictates management or is viewed as the only source of knowledge.

In addition, we have published a number of monographs for professionals. Our principal work addresses how meaningfully differing depressive disorders may be diagnosed and managed,[10] and our book on bipolar II disorder[11] – the first monograph ever prepared for a professional audience on this topic – was so successful that it led to a second edition published early in 2012.[12] In stepping down as Executive Director of the Institute at the end of 2011, I sought to capture aspects of my career and publish an autobiography, particularly focusing on my concerns about current diagnostic systems and the management of the mood disorders. To that end, the mid-third of this book[13] is devoted to detailing the limitations to the current dominant diagnostic and management models. The Institute has a Publications Consultant (Kerrie Eyers) who edits all major Institute publications and has taken essays from our competitions forward into our published books with extraordinary perspicacity.

The Institute has also established an e-health facility with a number of tools that allow people to obtain information about mood disorders, take part in educational programs, monitor their mood states and engage in a range of other activities via electronic means (e.g., mobile phones). This is a growing area in health generally, particularly in Australia for mental health, and the Institute seeks to provide leadership and differing models.

The early MDU iterative model whereby clinical assessment and research inform and advance each other has therefore been further expanded by the organizational model, allowing research information to be promulgated via the website and incorporated into educational and e-health programs, with feedback from the community (directly and via the writing competitions) that informs our management models and often shapes other research pursuits.

The Institute's success has been advanced distinctly by having a large number of supporters, including very prominent people (e.g., politicians, sportsman and artists) in the Australian community who tell their personal story about their mood disorder openly and frankly and who have advanced destigmatization distinctly in the Australian community. The Institute employs a volunteer coordinator who assigns our volunteers to tasks appropriate for their skills (e.g., data entry, giving a talk, assisting with a community activity, editing our publications). This coordination not only assists us across a stream of activities but adds breadth to the Institute in advancing a partnership model. A Corporate Relations and Development manager is responsible for advancing fundraising and marketing initiatives and linking

the Institute with corporate organizations and benefactors. From inception, the Institute had a Communications Manager who forged links with the media, a central activity in informing the public about what is happening at the Institute and providing professional information to journalists on the nuances of mood disorder.

The Institute often goes on the road, not only by providing educational talks in urban and rural areas but also by engaging in sporting events. For example, we have cyclists who might be on the road for a couple of days and, in addition to raising funds for the Institute, give public talks along their ride and distribute information from the Institute. A similar activity is a motorbike ride from different major capital cities (i.e., Sydney, Adelaide, Brisbane, Darwin, Melbourne and Perth) to the Red Centre of Australia (i.e., Alice Springs) that obtains considerable media attention. We have tried to link the importance of exercise to mood disorders by taking part in a number of sporting events (e.g., fun runs, community swims, etc.) both in Australia and even internationally, with participants again flying the flag of the Institute. Links with major sporting organizational bodies (e.g., rugby union, rugby league, cricket, swimming) have been forged. Such activities spread information, advance destigmatization, align depression management with exercise and raise funds.

The Institute has now been in existence for ten years. It has met many needs, including those of patients who sought diagnostic and management information, of families and friends who sought assistance for a relative through the maze, of professionals for education and training, and of researchers who wished to pursue both broad and specialized research inquiries. The whole became greater than the sum of the parts, operating at the individual level to the community level. The building's modern stylistic components provide a model of a psychiatric facility lacking any psychiatric institutional ambience, while the linkage between professional staff, volunteers and consumers offers a non-hierarchical parity model communicating a "we're all in this together" message. Finally, the Institute has advanced hope for its constituents – those with a mood disorder. As observed by Lin Yutang: "Hope is like a road in the country: there was never a road, but when many people walk on it, the road comes into existence".

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Disclosures

Gordon Parker
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*** Significant. Amounts given to the author's institution or to a colleague for research in which the author has participation, not directly to the author.

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