Research on Social Work Practice
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Research on Social Work Practice 2010 20: 302 originally published online 1 April 2010
DOI: 10.1177/1049731509347879

The online version of this article can be found at:
http://rsw.sagepub.com/content/20/3/302

Published by:
SAGE
http://www.sagepublications.com

Research on Social Work Practice
20(3) 302-320

DOI: 10.1177/1049731509347879
http://rswp.sagepub.com
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Evidence-Informed Practice: Antidote to Propaganda in the Helping Professions?

Eileen Gambrill[1]

Abstract

The most concerning issue affecting the quality of practices and policies in the helping professions is the play of propaganda, which misleads us regarding what *is* a problem, how (or if) it can be detected, its causes, and how (or if) it can be remedied. Propaganda is defined as encouraging beliefs and actions with the least thought possible. Censorship is integral to propaganda including hiding well-argued alternatives and lack of evidence for claims. Evidence-based practice was developed in part because of misleading claims in the professional literature. If propaganda is an integral part of our society, we cannot escape its influence. But we can become aware of it, encouraged by ethical obligations to avoid harming in the name of helping.

Keywords

evidence-based practice, propaganda, ethics

I suggest that the most concerning issue affecting the quality of practices and policies in social work, as well as in other helping professions, is the play of propaganda, which misleads us regarding what *is* a problem, how (or if) it an be detected, what are its causes, and how (or if) it can be remedied as illustrated by promoting anxiety in social situations as a mental disorder (Lane, 2007; Moynihan & Cassels, 2005). Propaganda is defined as encouraging beliefs and actions with the least thought possible (Ellul, 1965). The major kind of propaganda in the helping profession consists of inflated claims of knowledge: (a) claims regarding the effectiveness of certain products and services, including assessment methods and frameworks; (b) claims about what is a problem or risk; (c) claims about alleged causes of concerns; (d) claims about the competence of professionals; and (e) claims regarding what certain research methods can or cannot test. We live in a sea of propaganda pitches, including propaganda in the helping professions and related industries such as big pharma (the pharmaceutical industry), biotech companies, the psychological assessment industry, and the health insurance industry. Propaganda promoted by pharmaceutical companies has become so prevalent and conflicts of interests between academic researchers and such companies so huge, that a vigorous backlash is now in progress as illustrated by the groundbreaking investigations initiated by Senator Charles Grassley of Iowa, resulting in exposes of fraud and corruption on the part of academic researchers and the recent report of conflicts of interests by Lo and Field (2009). Senator Grassley is now investigating financial ties between advocacy groups such as the National Alliance for the Mentally Ill (NAMI) and the pharmaceutical industry (Harris, 2009). Common propaganda ploys in the helping professions include the following:

- hiding limitations of research studies (Altman, 2002; MacCoun, 1998; Rubin & Parrish, 2007);
- preparing uncritical, incomplete research reviews related to a practice or policy;
- ignoring counterevidence to views promoted (e.g., Barkley et al., 2002);
- selective publication of research studies (e.g., Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008);
- ignoring well-argued alternative views and related evidence or misrepresenting them;
- transforming risks into diseases (e.g., osteoporosis);
- biased estimates of the prevalence of concerns; advocacy in place of evidence (e.g., Best, 2001);
- arguing ad hominem (e.g., attacking the critic) rather than ad rem (responding to the argument; see Table 1).

These propaganda ploys result in inflated claims about "what we know" about causes, about accuracy of assessment measures, about risks, and about the effectiveness of remedies. Marcia Angell (2009) concludes:

> It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no

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Table 1. Indicators of Propaganda

Present only data that support views and hide (censor)evidence/arguments that do not;
- discourage critical appraisal of claims;
- distort and suppress competing well-argued views.
- inflated claims (puffery); excessive claims of certainty (We have "the way");
- personal attacks/ridicule;
- presentation of information/issues/views out of context (e.g., hide sponsors of material);
- vagueness that obscures interests and arguments (weasel words and phrases such as "It may be that . . . "; "Some people say . . . "; "Experts suggest . . . ");
- emotional appeals;
- appeal to popular prejudices;
- reliance on informal fallacies such as unfounded authority, manner of presentation, popularity, tradition, and glittering generalizations to support claims;
- use of case examples and testimonials;
- reliance on association and suggestion such as negative innuendoes;
- claiming one thing but doing another;
- repetition;
- oversimplification.

> pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of *The New England Journal of Medicine* (p. 12).

Researchers may promote questionable conclusions as described by Vul, Harris, Winkielman, and Pashler (2009). Professionals we trust to guard our interests may have been propagandized by material prepared by public relations firms hired by pharmaceutical companies (Moynihan & Cassels, 2005).

Concerns about the influence of pharmaceutical companies are reflected in the report of Lo and Field (2009), *Conflicts of Interests in Medical Research, Education and Practice* (see also Cosgrove, Bursztajn, Krimsky, & Anaya, 2009). Such influences are typically hidden and appeal to taken-for-granted views in a society such as the assumption that hundreds of behaviors are mental illnesses. They are the sea (often of propaganda) in which we live. The extent of industry support for continuing medical education is suggested by activity in 2003; the total income of all accredited providers was $1,774,516,395 (Brody, 2007, p. 204). Here are some examples of propaganda in the helping professions:

1. Brochures designed to encourage women to be screened for breast cancer by having a mammogram do not describe harms of screening such as over-diagnosis and subsequent over-treatment of healthy women (Gøtzsche, Hartling, Nielsen, Brodersen, & Jørgensen, 2009; Jørgensen and Gøtzsche, 2004).
2. Lilly, the pharmaceutical company, hid the fact that taking Zyprexa increased the risk of diabetes. This is but one of scores of examples of pharmaceutical companies hiding negative effects of drugs they promote (Brody, 2007).
3. Authors of articles make claims that cannot accurately be made based on methods used (Rubin & Parrish, 2007; Wampold et al., 2009).
4. An International Consensus Statement about ADHD (attention-deficit hyperactivity disorder) was signed by more than 100 people but contains two pages of text with no well-reasoned responses to criticisms but many ad hominem attacks on critics (Barkley et al., 2002).
5. Osteoporosis is described as a disease when it is a risk factor (not a disease).
6. Promotion of lists of "best practices" based on flawed research (e.g., Gandhi, Murphy-Graham, Petrosino, Chrismer, & Weiss, 2007; Gorman & Huber, 2009)
7. A physician recommends an intrusive test (vacuum-assisted core needle biopsy) to diagnose a palpable breast lump and fails to inform her patient about a less intrusive test (fine needle aspiration).
8. A continuing education instructor does not tell his audience that there have been no critical tests of his claim that a "new" therapy is effective.
9. A psychologist does not tell her client about alternative methods that have a better track record of success compared to the intervention she recommends.
10. A researcher does not describe key limitations in his research in a published article.
11. An instructor in a professional education program misrepresents a well-argued alternative view that competes with her favorite practice theory.
12. Doctors who accept money from drug companies prescribe more drugs produced by these companies some of which may do more harm than good.
13. A social work textbook misrepresents a major theoretical approach that has led to the development of effective programs for children and adults.

Professionals as well as clients are often bamboozled by false claims in professional journals and textbooks as well as in the media about what is helpful and what is not. Ioannidis (2005) argues that most published research findings are false. Conclusions often are not supported by methodologies used (Rubin & Parrish, 2007). Most services are of unknown effectiveness. The distinctions among services of different degrees

of effectiveness are obscured by propaganda in the helping professions. The importance of critically appraising claims of knowledge and the strategies used to forward them in the helping professions is highlighted by harming in the name of helping. Indeed, it was in part because of bogus statements in texts, editorials, and professional articles that evidence-based practice (EBP) was developed (Gray, 2001a). Peer review is deeply flawed as a gate-keeping process for quality (e.g., Smith, 2006).

Propaganda ploys can be seen in distortions and misrepresentation of EBP which abound (Gibbs & Gambrill, 2002). EBP is a way to help practitioners to handle uncertainty in an informed, ethical manner. Evidence-informed decision making is an alternative to authority-based decision making in which criteria such as consensus, anecdotal experience, or tradition are used.

"[EPB] is the conscientious, explicit, judicious, use of current best evidence in making decisions about the care of individual patients" (Sackett, Richardson, Rosenberg, & Haynes, 1997, p. 2).

Evidence-based health care refers to use of the best current knowledge as a basis for decisions about groups of patients or populations (Gray, 2001b).

EPB involves searching for research related to important decisions and sharing what is found, including nothing, with clients. It involves a search not only for knowledge but also for ignorance. Such a search is required to involve clients as informed participants whether this concerns a screening test for depression or an intervention for depression. The process and philosophy of EBP as described by its originators is designed to weed out bogus claims and involve all interested parties as informed consumers. The invention of the Internet and related tools were integral to this process as illustrated by the Cochrane and Campbell Collaborations and the many databases now available (e.g., netting the evidence, TRIP database, Bandolier, How to Read a Paper, DUETs, medscape, PsychInfo). The purpose of the Cochrane and Campbell Collaborations is to prepare, distribute, and maintain high-quality systematic reviews related to specific practice and policy questions. The first Leonard Gibbs Award was given to the best systematic review of the year in the area of social welfare (Winocur, Holtan, & Valentine, 2008) at the Campbell Collaboration Conference in Oslo, Norway, May 2009.

Although descriptions of the original vision of the process and philosophy are widely available, this is often, if not typically, ignored and a narrow authoritarian view is promoted, EBPs (the EBPs approach; e.g., Norcross, Beutler, & Levant, 2006). The unique five-step process and much of the philosophy of EBP are ignored and authoritarian practices continued (business-as-usual). In the EBPs approach, researchers and/or administrators decide what practices are "best practices" and "tell" practitioners what to do. This ignoring and distortion of the original vision of EBP has been a marked propaganda success (Gambrill, 2006). The distortion of the deeply democratic, participatory, and transparent process and philosophy of EBP is an illustration of the power of propaganda to maintain authority-based decision-making. In addition, just as we need critical appraisal of the methodology used in research studies, we also need critical appraisal of the way problems are defined, for example as mental illnesses, and their claimed prevalence. For example is it true as claimed in *Transformative Neurodevelomental Research in Mental Illness* (2008) that "One out of every 17 Americans suffers from a severe mental illness in their lifetime?" (Kessler, Chin, Demler, & Walters, 2005; see critique by Narrow, Rae, Robins, & Regier, 2002.)

What is Propaganda?

Propaganda (encouraging beliefs and actions with the least thought possible) can be contrasted with critical thinking, defined as arriving at well-reasoned beliefs and actions based on critical appraisal of related arguments and evidence.

> . . . To be effective, propaganda must constantly short-circuit all thought and decision. It must operate on the individual at the level of the unconscious. He must not know that he is being shaped by outside forces (this is one of the conditions for the success of propaganda), but some central core in him must be reached in order to release the mechanism in the unconscious which will provide the appropriate—and expected—action (Ellul, 1965, p. 27).

We can persuade people via a clear description of arguments, including their premises and conclusions and related evidence, or via a variety of propaganda pitches that distort, evade, and confuse (Altheide and Johnson, 1980; Damer, 2005; Engel, 1994; Jowett & O'Donnell, 2006; Patton, 2004; Pratkanis & Aronson, 2001; Skrabanek & McCormick, 1998). *Reasoning* (true rhetoric) involves a *critical evaluation of claims* and their context. This is quite different from the manipulative discourse of propaganda. Bennett and O'Rourke (2006) note that people have suggested the need to use rhetoric to limit its potential for abuse. In palaver, truth is irrelevant; there is no concern for truth, only to create credibility and for guile and charm (Combs & Nimmo, 1993). As Frankfurt (1986) suggests, " . . . he does not reject the authority of truth, as the liar does, and oppose himself to it. He pays no attention to it at all" (cited in Coombs & Nimmo, p. 242). Frankfurt (2005) argues that "Bullshit is unavoidable whenever circumstances require someone to talk without knowing what he is talking about" (p. 63). Propaganda in the helping professions and related venues flourishes in large part because of our ignorance, for example about the role of public relations agencies in creating alleged diseases as described later. The study of ignorance (agnotology) addresses the disappearance of knowledge and lack of use of knowledge, for example about the history of harming in the name of helping in psychiatry (Proctor & Schiebinger, 2008).

Propagandists take advantage of cognitive biases such as confirmation biases, overconfidence, and our tendency to oversimplify complex events (e.g., Gambrill, 2005). We think that because a specific term or word is used, such as

"borderline-personality disorder," or "depression," that we understand what this word refers to when we may not. We tend to confuse description (for example of symptoms related to a complaint of depression), with explanation (understanding the causes of the symptoms). Pseudoscience makes use of a variety of propaganda methods including using the language of science to promote dubious methods and views (e.g., Lilienfled, Lynn, & Lohr, (2003); Jacobson, Foxx, & Mulick (2005). Familiarity with a concept creates an (incorrect) impression of knowledge. That is, simply hearing a word representing a concept creates the impression that the hearer is familiar with what the term means, when they are not (Renner, 2004). This effect is a great hindrance to acquiring knowledge because we believe we already have it.

Definitions of propaganda highlight its contrast to critical, open-minded inquiry. Propaganda shapes beliefs and behavior with little thought (Ellul, 1965). It is used to influence the choices we make while giving us the illusion that we freely make these choices—*the illusion of choice*. Propaganda pitches create an illusion of openness, while at the same time, obscuring competing views and questionable grounds for assertions. Related strategies are carefully tailored to appeal to our self-interests and deepest motives, for example to be right, to be a member of the in-group, in order to discourage critical appraisal. Consider the following:

- Participating in a full body diagnostic scan designed to catch and prevent illness.
- Placing a child on Ritalin.
- Taking Paxil to decrease anxiety.
- Attending a National Screening Day for Anxiety Disorder.

In each example, we can ask whether a choice is well-reasoned and freely made or based on questionable grounds such as appeals to fear or popularity and engineered by others such as public relations firms employed by pharmaceutical companies or professional organizations. In each, we can ask, "How good is the evidence?" (e.g., Evans, Thornton, & Chalmers, 2006; Gambrill, 2005.) In each, we should ask whether the choice we make will result in more good than harm or more harm than good, and how can we find out? We are not free if we are not informed. Assuring us that we are free in such circumstances is a propaganda ploy. Propagandists take advantage of our deepest values and beliefs, typically reflected in the mass media from our earliest childhood. Such beliefs, as suggested by Ellul (1965), provide a sense of belonging. They are part of what he calls *pre-propaganda*, rife in our educational systems. Thus, we are complicit in being influenced by grand narratives promoted because we have embraced these and promote them ourselves. Indeed, Ellul (1965) argues that to be effective, propagandists must appeal to these grand narratives, such as a belief in unlimited progress.

The word "propaganda" was first used in 1622. Pope Gregory XV created the Sacra Congregatio de Propaganda Fide. The purpose of this papal propaganda office was to encourage people to accept church doctrines. This illustrates that the word "propaganda" is not necessarily negatively viewed—for example it was used positively by Catholics. The creation and diffusion of propaganda increased greatly with the invention of the printing press and the various forms of printed sources such as broadsheets, newspapers, bulletins, newsletters, and books and increased yet again with the development and wide use of electronic media such as radio and television. Another boost occurred during the two world wars; the dissemination of propaganda was viewed as a critical part of the war effort by the major countries involved in the world wars. Purveyors of propaganda draw on related social science.

> First of all, modern propaganda is based on scientific analysis of psychology and sociology. Step by step, the propagandist builds his techniques on the basis of his knowledge of man, his tendencies, his desires, his needs, his psychic mechanisms, his conditioning—and as much on social psychology as on depth psychology (Ellul, 1965, p. 4).

Edward Bernays (1923, 1928), the father of the field of public relations, showed that small groups of persons who understand and use propaganda can and do, by understanding the nature of human desire and taking advantage of the scientific study of public opinion and psychology, make the rest of us think what they please. The growth of the Internet provides another source of propaganda as well as sources designed to counter it such as www.healthyskepticism.org (See also Sweeney, 1997).

Propaganda hides influences on our decisions and information of value in making decisions. It uses misleading figures and misleading claims (e.g., Bausell, 2007; Best, 2001; Tufte, 2007; see Table 1). It hinders our autonomy to make our own decisions based on accurate information.

> It is a matter of reaching and encircling the whole man and all men. Propaganda tries to surround man by all possible routes, in the realm of feelings as well as ideas, by playing on his will or on his needs, through his conscious and his unconscious, assailing him in both his private and his public life. It furnishes him with a complete system for explaining the world, and provides immediate incentives to action. We are here in the presence of an organized myth that tries to take hold of the entire person. Through the myth it creates, propaganda imposes a complete range of intuitive knowledge, susceptible of only one interpretation, unique and one-sided and precluding any divergence . . . (Ellul, 1965, p. 11).

In *The Propaganda Menace* (1933), Lumley defined propaganda as: " . . . promotion which is veiled in one way or another as to (1) its origin or sources, (2) the interests involved, (3) the methods employed, (4) the content spread, and (5) the results accruing to the victims—any one, any two, any three, any four, or all five" (p. 44); " . . . any given promotional undertaking is to be regarded as propaganda when there is a camouflage or deception applying to aims, methods used and results." Related rules include the following: (a) Do not address real issues. (b) Attack the person or his or her

Table 2. Mental Illness Model and Rank's (1984) Fourfold Classification of Propaganda

Overemphasize the positive aspects of preferred model
Inflated claims of success in removing complaints (puffery).
Inflated claims of success in avoiding problems (puffery).
Hide and minimize negative aspects of preferred model.
Harmful effects of neuroleptic drugs.
Questionable reliability and validity of psychiatric classification systems (e.g., Caplan & Cosgrove, 2004; Kirk, 2004; Kutchins & Kirk, 1997).
Overemphasize negative aspects of opposing views.
Associate alternative approaches with negative terms (mechanistic, dehumanizing).
Allege that positive effects of alternative approaches are only temporary.
Hide and minimize positive aspects of opposing views (e.g., behavior analysis).
Ignore positive results achieved by alternative approaches.
Ignore lack of adverse effects with alternative approaches.

associates (try to spoil their credibility). (c) Distort disliked positions and attack the distorted versions. (d) Cozy up to friends. (e) Scare the hell out of them (e.g., if they do not do X, they will lose their jobs). Rank (1994) views the essence of propaganda as hiding negative aspects of preferred views and emphasizing the positive ones and hiding the positive aspects of disliked alternatives and emphasizing the negative ones (e.g., see Antonuccio, Burns, & Danton, 2002; Bass, 2008; Moynihan, 2009; see Table 2). Consider hiding negative clinical trials and repeated publication of positive ones. Is not one person's propaganda another person's carefully gathered evidence? I do not think so, given these definitions of propaganda and critical inquiry. For example in the former, evidence against favored views is hidden.

Sociological and Psychological Levels

Analyses of propaganda that focus on the psychological level (persuasion) and on common propaganda ploys, such as appeal to fear, card stacking, bandwagon, and glittering generalizations, provide an incomplete view, omitting sociological, ethical, and epistemological questions and issues. Ellul (1965) makes a compelling argument for approaching the study of propaganda at the highest level, which takes into consideration the kind of society in which we live. This is the technological society, dominated by the mass media in which traditional sources of grounding such as religion and the family have waned, leaving us more adrift and in need of guidance (Ellul, 1964). He argues that propaganda fills this vital need. For anyone who wishes to think deeply about propaganda, *Propaganda: The Formation of Men's Attitudes* (Ellul, 1965) is must reading. By "technique," Ellul refers to a preoccupation with the requisites of productivity and cost-effective results applied to all areas of life. There is a press toward technical efficiency and systematization. "Propaganda is called on to solve problems created by technology, to play on maladjustments, and to integrate the individual into a technological world" (p. xvii).

Ellul (1965) argues that education is central to the effectiveness of propaganda, that it is a pre-condition. He refers to this as *pre-propaganda*—the conditioning of minds with vast amounts of incoherent information, already dispensed for ulterior purposes and posing as "facts" and as "education." He suggests that intellectuals are the most vulnerable to propaganda because: (a) they are exposed to the largest amount of secondhand unverifiable information; (b) they feel a need to have an opinion on important questions; and (c) they view themselves as capable of "judging for themselves."

> Characteristically propaganda uses facts and poses as truthful information; it instrumentalizes truth; it does falsify, but in ways that involve the use of truths and facts as much as possible; it exploits expectations and confusion; it overloads audiences with information; it relies upon murkier epistemic moves such as suggestion, innuendo, implication, and truncated modes of reasoning; it accords priority to credibility and being believed; it discourages higher epistemic values such as reflection, understanding and reasoning, and the accumulation of evidence and its procedural safeguards. The propaganda process also exploits a wide range of para-epistemic structures, practices, and values. . . . In many texts and contexts, the propagandist will pose as an objective discussant and reasonable respondent who encourages dialogue, but in such a way as to deflect audiences from harsher and more substantial truths . . . Quite simply, the term *propaganda* is really a handy place-marker because it summarizes this litany of epistemic deficits (Cunningham, 2002, p. 98).

Ellul's (1965) broad, integrative analysis carries us far beyond persuasion strategies and communication methods and critical thinking focused on fallacies.

Ellul (1965) distinguished between political and sociological propaganda. He defined the former as "techniques of influence employed by a government, a party, an administration, a pressure group, with a view to changing the behavior of the public. The choice of methods used is deliberate and calculated; the desired goals are clearly distinguished and quite precise . . . " (p. 62). The purpose of agitation propaganda is to encourage resentment as a route to rebellion. He defined sociological propaganda as "the group of manifestations by which any society seeks to integrate the maximum number of individuals into itself, to unify its members' behavior according to a pattern, to spread its style of life abroad, and thus to impose itself on other groups" (p. 62). Ellul argued that propaganda both creates needs and offers solutions for them. Consider for

example the relentless redefinition of problems-in-living as mental illnesses in need of help by experts illustrated by the increasing number of alleged mental illnesses included in the *Diagnostic and Statistical Manual of Mental Disorders* ([DSM]; APA, 2000; see also Conrad, 2007; Kutchins & Kirk, 1997; Szasz, 1987.) Not to have an opinion is to be "out-of-touch." Ellul views propaganda as offering ready-made opinions for the unthinking—ready-made justifications for prejudices and valued ideologies. It decreases anxiety and prevents confusion about "what to think," which occurs when contradictory facts and messages are considered. It allows us to identify with the heroes of society. It provides group belonging; we can be an "insider." In addition, we can feel superior to the excluded or allegedly deluded (e.g., those who question the HIV/AIDS connection or mental illness as a brain disease).

> . . . Man, eager for self-justification, throws himself in the direction of a propaganda that justifies him and thus eliminates one of the sources of his anxiety. Propaganda dissolves contradictions and restores to man a unitary world in which the demands are in accord with the facts. It gives man a clear and simple call to action that takes precedence over all else. It permits him to participate in the world around him without being in conflict with it. . . . " (Ellul, 1965, p. 159).

In integration propaganda, we become "adjusted" to accepted patterns. Propaganda serves the function of integrating us into our society, as illustrated by the social control functions of the helping professions and the emphasis on "adjustment." "In the midst of increasing mechanization and technological organization, propaganda is simply the means used to prevent these things from being felt as too oppressive and to persuade man to submit with good grace" (p. xviii). Ellul (1965) points out that "adjustment has become one of the key words of all psychological influence" (p. 107); "the aim is normalcy, in conformance with a certain way of life" (p. 107). As scholars of deviance point out, power is integrally involved in deciding what or who is deviant (Pfohl, 1994). More and more "experts" tell us what is and what is not healthy, who is adjusted and who is not. Ellul maintained that the major function of propaganda is to encourage action or inaction that helps to maintain the status quo or take it in a similar direction. He suggested that much of this kind of propaganda occurs under the guise of education.

> . . . Propaganda's content increasingly resembles information. It has even clearly been proved that a violent, excessive, shock-provoking propaganda text leads ultimately to less conviction and participation than does a more "informative" and reasonable text on the same subject. A large dose of fear precipitates immediate action; a reasonably small dose produces lasting support. The listener's critical powers decrease if the propaganda message is more rational and less violent (Ellul, 1965, pp. 85-86).

Political, social, and economic aims are pursued in the guise of educating professionals and helping clients. Integrative propaganda is the most insidious kind because we do not rebel against it. A key aim of all propaganda is to obscure contingencies (associations between our behavior and environmental consequences) that if noticed, would result in countercontrol. Could this be a key reason applied behavior analysis has not been more popular? "Overt propaganda is necessary for attacking enemies . . . . But covert propaganda is more effective if the aim is to push one's supporters in a certain direction without their being aware of it. . . . " (pp. 15-16).

> We must also distinguish between covert propaganda and overt propaganda. The former tends to hide its aims, identity, significance, and source. The people are not aware that someone is trying to influence them, and do not feel that they are being pushed in a certain direction. This is often called "black propaganda." It also makes use of mystery and silence. The other kind, "white propaganda," is open and aboveboard. There is a Ministry of Propaganda; one admits that propaganda is being made; its source is known; its aims and intentions are identified. The public knows that an attempt is being made to influence it (Ellul, 1965, pp. 15-16).

Propaganda as Integral to a Technological Society

We live in a technological society, one pervaded by technicians and professionals of all sorts. Loeske (1999) uses the term "social problem industry" to refer to all those involved. Ellul (1964) approaches technology in a broad sense, far beyond the invention of machines. Technology presses toward efficiency, standardization, systematization, and the elimination of variability, which requires inattention to individual differences. Organizations and bureaucracies are techniques. Case records and surveillance systems are technologies (Illich, 1976; Margolin, 1997). The psychiatric classification system is a technique. Human relations and psychotherapy are techniques. Cognitive therapy methods reduce us to our thoughts. Biological views reduce us to brain chemistry. Illouz (2008) argues that the culture of therapy focuses on techniques of communication in which our emotions are decontextualized and endlessly measured. All ignore cultural, individual contexts, and complex interactions among them (e.g., Double, 2006). Moral dilemmas are obscured (e.g., Elliot & Chambers 2004; Szasz, 1994). Ellul's (1965) sociological analysis of the role of propaganda in a technological society requires consideration of the "big picture" (the total context) in understanding propaganda in the helping professions and possible remedies, including the consumer-oriented society in which we live—defining ourselves by the commodities we possess—including the "appropriate" communication styles emphasized in the culture of therapy, which are also promoted in corporations (Illouz, 2008).

The Role of the Helping Professions in Society

In addition to providing help with certain kinds of problems, professions have political, social, and economic functions and

interests (e.g., Larson, 1977). Professional practice today ranges from services based on the latest research in which clients are involved as informed participants to the continued use and dissemination of services that have been carefully evaluated and found to be harmful. This mix of helping efforts reflects the diverse, often conflicting, functions of the ''helping professions'' and the social judgments and related social control aims (rather than empirical evidence) used to define and respond to social and personal problems and suggest remedies (e.g., Pfohl, 1994; Szasz, 1994; Summerfield, 2001). In addition, it reflects the play of propaganda in the promotion of favored views. Professionals and related industries such as the pharmaceutical and social problem industries (Loeske, 1999) are integrally involved in defining problems and deciding what should be done about them: what is healthy (good) or unhealthy (bad) (e.g., Conrad, 2007). Social control is a key function of the helping professions. This refers to encouraging adherence to social norms and minimizing, eliminating, or normalizing deviant behavior. Mimi Abramowitz argues that since colonial times, social welfare policies have treated women differently based on the extent to which their lives conformed to certain family ethics (1988, pp. 3-4). Consider the traveling exhibit ''Mrs. DoCare'' and ''Mrs. DontCare'' depicting homes of both good and careless housekeepers designed to promote values compatible with social work (Tice, 1998). Other strategies of social persuasion used to promote the benefits of social work included the case record, urban surveys, docudramas, human interest stories, and social welfare theater (Routzahn, 1920; Tice, 1998). The language of caring and nurturance obscures paternalistic and manipulative and coercive practices. Katz argues that welfare has often been designed ''to promote social order by appeasing protest or disciplining the poor'' (1989, p. 33). Authoritarianism often reigns in the medical profession, especially where women and children are involved (e.g., Chalmers, 1983).

A moment's reflection on the different interests and functions of the helping professions highlights the potential for conflict and contradiction. Goals of social control may compete with goals of helping clients and of honest descriptions of research findings related to recommended methods; have they been critically tested and found to do more good than harm? This is a common dilemma in child welfare settings in which social workers are mandated both to protect children and to help parents who have harmed (and may continue to harm) their children. Social control aims are often disguised as concerns about helping clients as can be seen from a history of institutionalized psychiatry (e.g., Szasz, 1994; Valenstein, 1986). Negotiating the optimal balance between individual freedom and the protection of others has been the subject of treatises both small and large. Conflicting goals lead to different opinions about what is a problem and how problems should be addressed. Decreases in public funding for research in universities has increased collaboration between universities and industries and resultant conflicts of interests (Angell, 2009; Lo & Field, 2009). Scholars of the history of science such as Bauer (2001) argue that this has created knowledge monopolies and research cartels in which dissenting opinions and major issues are censored. As always, a key question is who profits and who loses from a particular point of view.

Indicators and Aims of Propaganda in the Helping Professions

Propaganda in the helping professions creates and maintains the belief that professionals are in possession of unique knowledge that can benefit those they claim to serve. A key function of such propaganda is to maintain and expand turf by obscuring mismatches between claims and their evidentiary status, for example by rechristening an ever increasing number of problems, including ethical and moral dilemmas, as mental illnesses in need of expert attention (e.g., Conrad, 2007; Elliot & Chambers, 2004; Moynihan, & Cassels, 2005; Szasz, 1994). Indications that propaganda is alive and well in the helping professions is suggested by the following:

- Distortions of EBP as discussed earlier.
- Ad hominum attacks on those who point out conflicts of interest and raise questions regarding research reports. For example, in a letter to the editor of *The British Medical Journal*, Leo and Lacasse (May 3, 2009) noted that the author of an article published in *The Journal of the American Medical Association* did not mention that a psychosocial intervention was as effective as an antidepressant for post-stroke depression nor did he mention a conflict of interest he had (a financial tie to a pharmaceutical company). The editor-in-chief of JAMA, Catherine De Angelis called Leo a ''nobody and a nothing.'' One author received threats from Fortanarosa, the Executive Deputy Editor of JAMA: ''Who do you think you are? You are banned from JAMA for life . . . '' (Armstrong, *Wall Street Journal* blog March 13, 2009.) Antonuccio and Healy (2009) refer to this sequence of events as ''stealth advertising and academic stalking'' (see also Leo, 2009).
- Clients have been killed as a result of methods such as ''rebirthing.'' Some scholars suggest that the history of psychiatry is one of harming in the name of helping (e.g., Scull, 2005; Valenstein, 1986). Attention to adverse effects of professional services is relatively recent (Sharpe & Faden, 1998). It is estimated that up to 98,000 medical patients die each year from iatrogenic causes (Kohn, Corrigan, & Donaldson, 2000; see also Leape, & Berwick, 2005). There is little attention to adverse events in psychology and social work.
- Programs that have been critically tested and found to be harmful are widely used. For example, ''Scared Straight'' programs designed to decrease delinquency have been shown to increase it (Petrosino, Turpin-Petrosino, & Finckenauer, 2000) but are still used.
- Most assessment and intervention methods used are of unknown effectiveness in relation to hoped-for outcomes; they have not been critically tested to determine whether they do more good than harm.

- Many programs that have been critically tested and found to be helpful are not widely used.
- Most clients are not involved as informed participants in making decisions. That is, they are not accurately appraised of the evidentiary status of recommended procedures and alternatives including the alternative of doing nothing—watchful waiting (Braddock, Edwards, Hasenberg, Laidley, & Levinson, 1999). Many people described as mental patients, are not informed that recommended medications may result in irreversible side effects such as the uncontrollable physical movements in tardive dyskinesia (e.g., Brown & Funk, 1986).
- Controversies regarding the evidentiary status of practices and policy are often hidden. Consider for example Littell's (2005, 2006) critical appraisal of Multisystemic Family Therapy.
- Inflated claims of effectiveness abound; they misrepresent (inflate) the evidentiary status of methods, often by hiding limitations of research such as lack of a comparison group (e.g., Gandhi et al., 2007; Gorman & Huber, 2009; Jacobson et al., 2005; Lilienfeld, Lynn, & Lohr, 2003; Rubin & Parrish, 2007). Corporate interests in maximizing profits, for example on the part of pharmaceutical companies, encourage bogus claims in the pursuit of profits (Angell, 2005, 2009; Brody, 2007; Kassirer, 2005; Lane, 2007; Medawar & Hardon, 2004; Petersen, 2008). If professionals are so effective in resolving or preventing problems as claimed in book titles such as *A guide to treatments that work* (Nathan & Gorman, 2007) and *What works in child welfare* (Kluger, Alexander, & Curtis, 2002), why do problems remain so prevalent?
- Screening programs, for example for depression and anxiety, are promoted even though there is no evidence that they do more good than harm. These often are subsidized by professional organizations and pharmaceutical companies with special interests. Adverse effects of screening for breast cancer via mammograms, such as the high rate of false positives resulting in unnecessary biopsies have typically been hidden until recently (Gotzsche et al., 2009; Rabin, 2009; Welch, 2004).
- Hiding controversies and lack of evidence regarding alleged causes of troubling behaviors, for example bold assertions that delusions or hallucinations are due to "schizophrenia" (Boyle, 2002), and claiming that misbehaviors on the part of children are the result of a "brain disease" (Baughman & Hovey, 2006; Leo & Cohen, 2003). In *The ADHD Fraud* (2006), Baughman argues that creation of pseudodiseases such as "ADHD" and drugging those labeled actually creates brain abnormalities. He as well as others (e.g., Boyle, 2002; Moncrieff, 2008) argue that behaviors that disturb adults are viewed as signs of neurobiological abnormality when no proof of such abnormality is offered. Well-argued alternative views attending to environmental variables are typically ignored (e.g., Timini, 2002).

The Creation of Pseudodiseases

Disease mongering is rampant (Payer, 1992). Disease mongering on the part of pharmaceutical companies expands alleged illnesses by rendering everyday mood changes and behaviors as "diseases" in need of attention (e.g., Elliott & Chambers, 2004; Horowitz & Wakefield, 2007; Moynihan & Cassels, 2005; Summerfield, 2002). Brody (2007) as well as Moynihan and Cassels (2005) describe how public relations firms hired by drug companies create and promote diseases such as "social anxiety disorder" and "overactive bladder" to be remedied by their drugs. Normal variations in behaviors and feelings are transformed into mental illnesses:

> In recent years, drug companies have perfected a new and highly effective method to expand their markets. Instead of promoting drugs to treat diseases, they have begun to promote diseases to fit their drugs. The strategy is to convince as many people as possible (along with their doctors of course) that they have medical conditions that require long-term drug treatment (Angell, 2009, p. 10).

Disliked behaviors are transformed into alleged brain diseases and medication is recommended. Consider the thousands of children on Ritalin (Baughman & Hovey, 2006). Students in professional education programs are often indoctrinated into use of psychiatric labels for illusionary diseases and become active diagnosticians of pseudopathology (e.g., Lacasse & Gomory, 2003).

The increasing role of pharmaceutical companies in medicalizing everyday concerns is described by many authors (e.g., Angell, 2005; Hadler, 2004; Kassirer, 2005; Moynihan & Cassels, 2005). The more bogus "illnesses" can be created, especially for the "healthy," the more drugs can be sold. The more "the healthy" can be lured into concerns about bogus risks, the greater the pool of potential buyers. In *Selling Sickness*, Moynihan and Cassels (2005) point out that 30 years ago, the CEO of Merck informed *Fortune* magazine that "the company's potential markets [have] been limited to sick people" and he hoped "to make drugs for healthy people" (p. ix). Direct to consumer advertising (DCA), initiated in 1997, allows pharmaceutical companies free reign to suggest new risks and illness and to offer remedies. Billions of dollars are spent by pharmaceutical companies on advertisements designed to encourage consumption of their products. Content analysis of television DCA shows these ads to be deceptive (Frosch, Kruger, Hornik, Cronholm, & Barg, 2007). These ads provide little educational information and show individuals who have lost control over their lives but regain it via medication, including social approval (Frosch et al., 2007). Furthermore, claims made in many ads that various mental disorders are caused by a lack of serotonin remedied by medication, is contradicted by related research (LaCasse & Leo, 2005). Press releases given to journalists describing "startling" discoveries are passed on to the public who are often all too unskeptical of claims about risks or the effectiveness of a product or service (Boynton, Shaw, & Callaghan, 2004).

A key role of public relations and advertising firms hired by pharmaceutical companies is to create a need for remedies offered by drug companies. Consider the promotion of "social anxiety disorder" as a mental illness and the marketing of Paxil as a remedy. The pharmaceutical company GlaxoSmithKline (GSK) hired Cohn & Wolfe, a public relations firm that specializes in unconventional ways to market pharmaceuticals, "to *position* social anxiety disorder as a severe condition" (Moynihan & Cassels, 2005, p. 121). Advocacy groups provided suffering patients to talk to journalists. Public relations firms organized teleconferences with sufferers. Moynihan and Cassels (2005) point out that "This occurred *before* Paxil was even approved for the treatment of this condition, in order to give Cohn & Wolfe time to start 'cultivating the marketplace' (p. 121).

> In keeping with modern public relations techniques the PR firm helped orchestrate what looked like a grassroots movement to raise public awareness about a neglected disorder. The awareness raising campaign was based on the slogan "Imagine being allergic to people." Posters that featured a sad-looking man and listed commonly experienced symptoms were distributed across America. "You blush, sweat, shake—even find it hard to breathe. That's what social anxiety disorder feels like." The posters appeared to come from several medical and advocacy groups under the umbrella of the Social Anxiety Disorder Coalition: all three members of the "coalition" rely heavily on sponsorship from drug companies. Calls from the media to the "coalition" were handled by Cohn and Wolfe (pp. 121-122).
>
> In the space of little more than a year Paxil's manufacturer GSK took a little-known and once-considered rare psychiatric condition and helped transform it into a major epidemic called social anxiety disorder—claimed at one point by the company to affect one in eight Americans. The transformation would ultimately help rack up sales of Paxil worth $3 billion a year, and make it the world's top-selling antidepressant (p. 120).

Selective omission (hiding the negatives—telling half-truths) was a key propaganda ploy of the selling of social anxiety disorder as an epidemic and Paxil as a remedy; hidden were withdrawal symptoms that can be so severe that people are unable to stop taking Paxil (p. 125).

As Moynihan and Cassels (2005) point out, as "with depression, part of the 'awareness-raising' about social anxiety disorder was designed to narrowly portray the condition as being caused by a 'chemical imbalance' in the brain, to be fixed with chemical solutions like Paxil" (p. 136). This "distracts all of us from a broader understanding of the complex sources of social anxiety—whether it is defined as a mental disorder or not" (p. 137). Hidden was the fact that "there was no good evidence that the antidepressants were any better than a placebo" (p. 134). *Partiality in use of evidence* is key in propaganda (censorship). The situation got so bad that Elliott Spitzer, then New York Attorney General, initiated a legal action against GSK, publicly accusing the company in 2005 of fraud. "He alleged the drug company concealed data about both the dangers of Paxil and the lack of evidence of benefit in depressed children, and it had therefore misled doctors and the public. Within three months GSK had settled the case. While it rejected the charges as unfounded, it did agree to pay $2.5 million to avoid the cost of protracted legal action with the State of New York" (p. 135). It was found that "an internal GSK memo sent to its drug detailers in 2003 specifically advises the company's sales representatives not to discuss the potential link with suicidal behavior with prescribing doctors" (p. 135).

Thus, all is not what it seems. For example, the creation of social anxiety as a highly prevalent mental disorder was a result of marketing rather than of scientific investigation. Ever more behaviors, thoughts, and feelings are described as mental illnesses. The word "healthy" is used in ever more venues. The sheer repetition of the grand narrative of "mental illness" encourages acceptance of this framing, which ignores the causal role of stresses created by an ever more encroaching technological society, especially for clients seen by social workers. Aging is increasingly being medicalized (e.g., Conrad, 2007). Women have been a key target for medicalization of normal processes such as menopause (Caplan, 1995; see also Moynihan, 2003). Researchers are influenced by this marketing in their investigation of presumed disorders. So too are those who teach in professional education programs and clinicians alleged to be "experts" in helping clients with assumed disorders and funders of research (e.g., see Midanik, 2006). This is particularly ironic in social work with its historical focus on social reform and current rhetoric regarding empowerment. The public is reeled in by hope for cures and relief from miseries, by awe of researchers and experts, and by the constant assault from ads alleging even more risks and offering presumed remedies. It is an old game played in increasingly sophisticated ways as new technologies allow ever more novel approaches, including individual targeting of different groups based on social and psychological research. Professions have well-organized national and state organizations dedicated to maintenance and expansion of turf often based not on claims of effectiveness that have survived critical tests but on bogus claims of success and on questionable criteria such as consensus and appeals to fear. Examples include the American Psychiatric Association, the American Psychological Association, the American Medical Association, and scores of others. Illich (1976) raised concerns about the medicalization of life in his classic book *Medical nemesis: The expropriation of health.*

In advertising, we are usually aware of the purpose of the advertiser—to sell services or products. In propaganda in other sources, the purposes are often hidden. Indeed, propaganda is often presented as education. Pharmaceutical companies fund most medical continuing education programs (Brody, 2007). Concerns about bias has resulted in calls for restriction of such funding (e.g., American Psychiatric Association News Release, March 25, 2009; Lo & Field, 2009; Rothman et al, 2009). A review of advertising on marketing brochures distributed by drug companies to physicians in Germany revealed that 94% of the content in these had no basis in scientific evidence

(reported in Tuffs, 2004;. see also Frosch et al., 2007) Presenting pitches for a product in an ''article'' form (''advertorials'') may lull readers into uncritical acceptance of promotional material (Prounis, 2004), as may reading articles in professional journals. Ghostwriting is common in which staff in a public relations firm write journal articles that appear under well-known researchers' names (Brody, 2007). Drug companies promote common concerns such as social anxiety and premenstrual dysphoria as ''mental illnesses'' to increase profits from sales of drugs. Consider also promotion of irritable bladder as a disorder. Public relations firms are hired by pharmaceutical companies to promote sicknesses and to convert normal behaviors into diseases (Brody, 2007; Petersen, 2008).

Marketing values and strategies, prevalent throughout time in selling nostrums for our maladies such as creating stories that appeal to our greatest hopes and worries, for example loneliness caused by bad breath (halitosis) (Marchand, 1985; McLuhan, 1951; Williamson, 2002), are common in the realm of professional education as well as published literature in the helping professions. Shared ploys include the creation of problems, needs, desires, and alleged risks and the use of marketing strategies to sell products and services to satisfy these needs and avoid these risks (e.g., Conrad, 2007). We are kept on tenderhooks, waiting to hear about the next avoidable risk, the next promised remedy to meet our needs, described not only in the media, but in professional journals and texts as well. Critical appraisals of practice-related literature in clinical psychology and psychiatry illustrate the prevalence of pseudoscience (Boyle, 2002; Jacobson et al., 2005; Lilienfeld et al., 2003), material with the trappings of science without the substance. There is enormous hubris—false claims of cures. Given that claims do not match reality, they are a form of propaganda. If harms result from such propaganda including choosing services that harm rather than help clients, removing opportunities for clients to help themselves, it is important to develop ways to avoid its effects. Harms include ill-advised transportation of psychiatric nomenclature to non-Western countries (Summerfield, 2008).

The Play of Propaganda

We can use the metaphor of a stage when thinking about propaganda (Hilgartner, 2000). Plays take place on a stage. ''Staging'' allows emphasis of different ideas, people, and backgrounds. This is the beauty of theater; we can create unique environments that portray different realities. A stage (like an advertisement or published article) allows us to hide or mute certain features of reality and to display and emphasize others in order to attain certain effects—this is exactly what propaganda strategies do. Consider for example the hiding of negative trials and repeated publication of those with positive results to promote sales of a drug (e.g., Brody, 2007; Peterson, 2008). There is front-stage and back-stage activity (Goffman, 1961). Brody (2007) argues that:

> . . . medicine has for many decades now been betraying this public trust in the way that it has accepted various benefits from the pharmaceutical industry. Medicine and the industry together have been very creative in thinking up rationalizations to make it seem as if all this behavior really serves the interest of the public after all. And medicine has also managed to convince itself that its world is divided into an on-stage and backstage portion. Patients, we imagine, see us on-stage but cannot peek behind the curtains and see us backstage. So long as some of the embarrassing exchanges between medicine and industry occur backstage, we think that no one will notice and public trust in the profession will not be compromised'' (p. 5).

Stage designers (like propagandists) design varied ways to create different ''realities.'' In successful plays, we suspend disbelieve as we enter the world of the playwright, the actors, and the set designers who bring different realities to life. With propaganda, we often do not realize that we have entered someone else's stage set, as in continuing education programs funded by pharmaceutical companies. Propaganda arranges a stage. It hides context. Propaganda in the helping professions hides history. It hides flawed methodologies and environmental contributors to concerns. It presents a distorted view of reality. It hides other actors eager to present other views; they are hidden in the wings, their myths and scripts are rejected, perhaps not even acknowledged. Different kinds of propaganda may enter a story line at different times as illustrated in the public relations campaign by Cohn & Wolfe to promote social anxiety as a disorder (Moynihan & Cassels, 2005). Self-propaganda such as inflated estimates of competence and propaganda from other sources are often symbiotically entangled. The cast of characters and their venues are quite varied in the play of propaganda in the helping professions. Players include researchers and academics who publish in professional journals, faculty who teach in professional education programs, the continuing education industry, consumer groups, journal editors and reviewers, politicians, Big Pharma, the biotechnology industry, clients and patients, the health care insurance industry, funding agencies such as the National Institute of Health, and governmental agencies such as the U.S. Food and Drug Administration (FDA; Harris & Carey, June 8, 2008). Interactions play out on a global scale as illustrated by the influence of the World Psychiatric Association on the World Health Organization ([WHO]; Medawar & Hardon, 2004). There are troubling interconnections between those with interests in the decisions made (e.g., pharmaceutical companies) and staff in regulatory agencies such as the FDA (Harris, December 6, 2004, *NYT*; Lenzer, 2004).

Propaganda as Key in Quackery, Fraud, and Corruption

Quackery refers to the promotion and marketing, for a profit, of untested, often worthless and sometimes dangerous health products and procedures, by either professionals or others (Jarvis, 1990; Young, 1992). Quackery takes advantage of a variety of propaganda methods designed to encourage beliefs and actions with the least thought possible such as testimonials and

appeal to our hope for cures. Indicators of quackery include the promise of quick cures and the use of anecdotes and testimonials to support claims. The history of quackery is fascinating (McCoy, 2000; Porter, 2000). There is a museum of medical quackery in Minneapolis, Minnesota.

Fraud is the intentional misrepresentation of the effect of certain actions such as taking a prescribed drug to decrease depression, to persuade people to part with something of value such as their money. It does this by means of deception and misrepresentation, drawing on a variety of propaganda ploys including the omission of relevant information such as harmful side effects. The *Merriam-Webster Dictionary of Law* defines fraud as:

> . . . any act, expression, omission, or concealment calculated to deceive another to his or her disadvantage; specifically: a misrepresentation or concealment with reference to some fact material to a transaction that is made with knowledge of its falsity or in reckless disregard of its truth or falsity and with the intent to deceive another and that is reasonably relied on by the other who is injured thereby.

The legal aspects of fraud in this definition include (a). misrepresentation of a material fact; (b) knowledge of the falsity of the misrepresentation or ignorance of its truth; (c) intent; (d) a victim acting on the misrepresentation; and (e) damage to the victim (Busch, 2008, p. 3). Fraudulent claims (often appealing to the trappings of science) may result in overlooking effective methods or being harmed by remedies that are supposed to help (e.g., Jacobson et al., 2005).

> Most of the big drug companies have settled charges of fraud, off-label marketing, and other offenses. TAP Pharmaceuticals, for example, in 2001 pleaded guilty and agreed to pay $875 million to settle criminal and civil charges brought under the federal False Claims Act over its fraudulent marketing of Lupron a drug used for treatment of prostate cancer. In addition to GlaxoSmithKline, Pfizer, and TAP, other companies that have settled charges of fraud include Merck, Eli Lilly, and Abbott. The costs, while enormous in some cases, are still dwarfed by the profits generated by these illegal activities, and are therefore not much of a deterrent (Angell, 2009, p. 12).

Corruption includes deceitful practices such as dumping unsafe drugs in third world countries and conflicts of interest that permeate medicine (Angell, 2005, 2008, 2009; Lo & Field, 2009; Sparrow, 2000). It includes bribery of officials and kickbacks for referrals. Krimsky (2003) argues that the lure of profit (greed) has corrupted biomedical research (see also Lock, Wells, & Farthing, 2001). Corruption in the health area is vast (Busch, 2008). Examples include selling or prescribing pills with no active ingredients or containing harmful substances. Corruption is so common that an international organization, Transparency International, was created to decrease it. Corruption, fraud and quackery, and propaganda methods used in their service compete against our "right-to-know" (Florini, 2007)—transparency and accuracy. Corruption and fraud are closely intertwined. In both, propaganda methods are used to forward self-interests in deceptive, manipulative ways. In "Drug Companies & Doctors: A Story of Corruption" (2009), Marcia Angell (2008) describes the promotion of the diagnosis of bipolar disorder in children as young as 2 years old by Dr. Joseph L. Biederman, Professor of Psychiatry at Harvard's Massachusetts General Hospital as well as treatment of such children with powerful drugs "many of which were not approved by the Food and Drug Administration (FDA) for that purpose and none of which were approved for children below ten years of age" (p. 8). She notes that his own studies were viewed by others as inconclusive.

Revelations of undeclared income from drug companies sparked a congressional inquiry spearheaded by Senator Charles E. Grassley. "After a series of stinging investigations of individual doctors' arrangements with drug makers, Senator Charles E. Grassley, Republican of Iowa, is demanding that the American Psychiatric Association, the field's premier professional organization, give an accounting of its financing" (Carey & Harris, 2008, p. 13). They note that "drug companies paid for 30% of the APA's $62.5 million in financing in 2006. About half of that money went to drug advertisements in psychiatric journals and exhibits at the annual meeting, and the other half to sponsor fellowships, conferences and industry symposiums at the annual meeting." Angell (2009) refers to such conflicts of interest as corruption. Lo and Field (2009) define conflicts of interest as

> circumstances that create a risk that *professional judgments or actions regarding a primary interest will be unduly influenced by a secondary interest*. Primary interests include promoting and protecting the integrity of research, the quality of medical education, and the welfare of patients. Secondary interests include not only financial interests—the focus of this report—but also other interests, such as the pursuit of professional advancement and recognition and the desire to do favors for friends, family, students, or colleagues" (S-4,5).

Continuing investigations have shown that many top academic psychiatrists have failed to report all their earnings as required. Thanks to investigations initiated by Senator Grassley, we now know that Biederman received $1.6 million in consulting and speaker fees between 2000 and 2007 from drug companies including those that manufactured drugs he advocated. Similar conflicts of interest were found concerning Dr. Alan Schatzberg, Chair of Stanford's Psychiatry Department and [then] President-Elect of the American Psychiatric Association. He owned millions of dollars of stock in Corcept Therapeutics, a company he cofounded that was testing the abortion drug RU-486 for psychotic depression (Angell, 2009, p. 8). He also was principal investigator on an NIMH grant to investigate this drug. Dr. Charles Nemeroff, Chair of Emory University Psychiatry Department reported income from GlaxoSmithKline of $10,000 and did not disclose $500,000 he received for giving talks. Marcia Angell (2009) estimates that gifts and fees to doctors from drug companies "comes to tens of billions of dollars a year" (p. 8).

> By such means, the pharmaceutical industry has gained enormous control over how doctors evaluate and use its own products. Its extensive ties to physicians, particularly senior faculty at prestigious medical schools, affect the results of research, the way medicine is practiced, and even the definition of what constitutes a disease (p. 8/10).
>
> In view of this control and the conflicts of interest that permeate the enterprise, it is not surprising that industry-sponsored trials published in medical journals consistently favor sponsors' drugs—largely because negative results are not published, positive results are repeatedly published in slightly different forms, and a positive spin is put on even negative results. A review of seventy-four clinical trials of antidepressants, for example, found that thirty-seven of thirty-eight positive studies were published. [Turner et al., 2008]. But of the thirty-six negative studies, thirty-three were either not published or published in a form that conveyed a positive outcome (Angell, 2009, p. 10).

Conflicts of interest noted by Lo and Field (2009) in their report for the Institute of Medicine include the following:

- physicians and researchers failing to disclose substantial payments from drug companies, as required by universities, government agencies, or medical journals;
- settlements with the U.S. Department of Justice by medical device and pharmaceutical companies to avoid prosecution for alleged illegal payments or gifts to physicians;
- companies and academic investigators not publishing negative results from industry-sponsored clinical trials or delaying publication for over a year after the completion of a trial;
- academic researchers putting their names on manuscripts, even though they first become involved after the data were collected and analyzed and after the first drafts were written by individuals paid by industry; and
- professional societies and other groups that develop clinical practice guidelines choosing not to disclose their industry funding and not to reveal the conflicts of interest of the experts who draft the guidelines" (S-2).

The Consequences of Propaganda

Possible consequences of propaganda in the helping professions include

- failing to receive effective services;
- creating bogus risks and alleged "diseases" and related worries, which drain life of its pleasures;
- increased dependency on professionals;
- forcing clients to accept unneeded and perhaps harmful diagnostic tests and other interventions;
- labeling normal variations in behavior as pathological;
- relapse (return of complaints).

Examples of harming in the name of helping from the past include the following:

- Mrs. A., a housewife, was diagnosed as mentally ill and hospitalized because she wanted to work.
- Mrs. Green, a depressed Philadelphia housewife, was sent to Trenton State Mental Hospital to have her teeth and colon removed in order to cure her depression based on the theory that mental illness is caused by focal sepsis (Scull, 2005).

Tens of thousands of lobotomies (brain surgeries) were carried out in the 1940s and 1950s (see El-hai, 2005). Egas Moniz who suggested this procedure, won the Nobel Prize for Medicine.

Here are some examples from current times:

- Mrs. B. took her daughter to a rebirthing therapist to help her. Her daughter died.
- The high incidence of adverse drug reactions from taking prescribed medication as prescribed (Lazarou, Pomeranz, & Corey, 1998).
- An estimated 44,000 to 98,000 Americans in hospitals die each year due to medical errors (Kohn et al., 2000; Leape & Berwick, 2005).

Ellul (1965) argued that the effects of propaganda are always negative (especially in a democracy) whether intentional or not. " . . . because rational propaganda thus creates an irrational situation it remains above all, propaganda—that is, an inner control over the individual by a social force, which means that it deprives him of himself" (p. 87). "(t)he force of propaganda is a direct attack against man—a menace which threatens the total personality" (Ellul, 1965). He suggests that propaganda

- alienates us from ourselves. We can no longer judge for ourselves;
- creates an illusion of freedom (we feel free but are not);
- reduces critical judgment and experimenting on our own;
- creates an inability to distinguish ourselves from society, institutions, and groups;
- destroys individuality, we are not at ease unless integrated into a mass;
- creates a dissociation between thought and action (e.g., we act without thinking and think without acting);
- encourages us to cling to certainties;
- discourages the growth of knowledge;
- encourages prejudice/hate; sets off ingroups and outgroups. " . . . for all propaganda is aimed at an enemy" (p. 152);
- discourages open discussion so vital in a democracy;
- decreases empathy for and understanding of others;
- creates resignation and inertia—"a general attitude of surrender" (p. 182);
- offers justification, for example for dreadful deeds;
- encourages a dysfunctional (to the person) standardization, conformity;
- encourages spectatorship.

> Propaganda strips the individual, robs him of part of himself, and makes him live an alien and artificial life, to such an extent

> that he becomes another person and obeys impulses foreign to him. He obeys someone else.
>
> Once again, to produce this effect, propaganda restricts itself to utilizing, increasing and reinforcing the individual's inclination to lose himself in something bigger than he is, to dissipate his individuality, to free his ego of all doubt, conflict, and suffering-through. Professor Gambrill fusion with others; to devote himself to a great leader and a great cause. In large groups, man feels united with others, and he therefore tries to free himself of himself by blending with a large group (p.169).

Lumley (1933) suggested that one of the gravest negative results of propaganda is to encourage fear and suspicion: "... propaganda diminishes human happiness ... by quickening and expanding the fears and suspicions of men" (p. 381). When propaganda is presented under the guide of education it encourages a misplaced trust that is especially pernicious. Propaganda in the helping professions obscures the problematic nature of popular views and therefore hinders understanding of and active pursuit of well-argued alternatives (e.g., Boyle, 2002; Moncrieff, 2008). It results in coercive treatments in the name of alleged "scientific findings" that are conceptually and methodological bogus such as inappropriate drugging of children (Baughman & Hovey, 2006). Harm includes removing valuable opportunities, locking people up against their will, stigmatizing clients by means of negative diagnostic labels (e.g., PsychDiagnosis.net) and not fully informing clients, with the result that they make decisions they otherwise would not make.

Exposing Propaganda and Avoiding Its Influence

Understanding the nature and prevalence of propaganda, its seductions, aims, and consequences, and keeping critical thinking skills well honed is vital in decreasing influence by propaganda in the helping professions and related harms including lost opportunities to help clients. Professional education programs may promote bogus views of reality and actively and passively discourage critical appraisal of educational formats and content as well as what is offered to clients. Only if we take a broad sociological view of propaganda do we have any chance of escaping its influence because of the appeal of grand narratives promoted such as "progress," "health," and "cure." Skinner (1953) has long advocated increasing our awareness of social, political, and economic contingencies to enable us to exert countercontrol to avoid unwanted influences, as have other authors such as Freire (1973).

> ... confronted by a necessity, man must become *aware* of it, [propaganda] if he is to master it. As long as man denies the inevitability of the phenomena, as long as he avoids facing up to it, he will go astray. He will delude himself, by submitting in fact to "necessity" while pretending he is free "in spite of it" and simply because he claims to be free. Only when he realizes his delusion will he experience the beginning of a genuine freedom in the act of realization itself be it only from the effort to stand back and look squarely at the phenomena and reduce it to raw fact (Ellul, 1965, p. xvi).

If propaganda is an essential part of the technological society in which we live as Ellul (1965) suggests, then we cannot escape its influence. Our only recourse is to try to understand how it works, how it may influence our lives, and for professionals, how it may influence the lives of clients, and how we may mute its effects. False beliefs about propaganda that may get in the way of spotting propaganda in the helping professions include the following:

1. We can avoid the effects of propaganda. Since we live in a sea of propaganda pitches and since these will fail unless they are compatible with our goals and deepest motives (such as to stay healthy and have a happy life), there is no way we can avoid their effects although we can become more aware of them and minimize their influence.
2. It is easy to avoid the effects of propaganda.
3. Propaganda consists of lies. Propagandists go out of their way to avoid telling lies that may be discovered and so discredit the "liar."

> For a long time propagandists have recognized that lying must be avoided. "In propaganda, truth pays off"—this formula has been increasingly accepted. Lenin proclaimed it. And alongside Hitler's statement on lying one must place Goebbels's insistence that facts to be disseminated must be accurate (Ellul, 1965, p. 53).

4. Distribution of propaganda requires a conspiracy. Most propaganda may be unplanned.
5. Good intentions can protect us from propaganda, especially in the helping professions—after all, are not professionals supposed to help? Indeed, propaganda runs rampant in related venues in part because we assume that good intentions will protect us from harm. They have not, as the history of the helping professions shows, and they will not.
6. We learn how to avoid the effects of propaganda in our education. Not true, as shown for example in concerns regarding the teaching of critical thinking values, knowledge, and skills (Paul, Elder, & Bartell, 1997). What is presented as education is often indoctrination (Gambrill, 1997; LaCasse & Gomory, 2003).
7. Professionals learn how to spot and avoid the effects of propaganda during their professional education. Although this may be true for some, including the few who take a special course designed to yield this happy outcome (e.g, Wilkes & Hoffman, 2001; Wofford & Ohl, 2005), it is not true for many professionals who do not learn how to critically appraise research related to problems their clients confront.
8. It appeals only to our emotions; indeed appeals to "reasoning" are often used. If we see a picture of a brain we are more likely to consider arguments in an article scientifically sound (McCabe & Castel, 2008).

Professionals and clients will need a variety of tools as well as courage to travel through the fields of seductions. No one describes these better than Ellul (1965). There are the siren calls of our own self-interests, illusions of knowledge and competence, and arrogance. Avoiding propaganda requires constant questioning. Is this true? What is the evidence? It requires the courage to be viewed as a troublemaker, to not be one of the boys/girls. You may be viewed as difficult. You may even get sued by a pharmaceutical company or lose a job. These are realities as demonstrated by withdrawal of a job offer to David Healy by the University of Toronto (Healy, 2004) and the intimidation of Dr. John Buse who raised questions in 1999 about the diabetes drug, Avandia (Stein, 2007; see also Gornall, 2009). Yet we must ask, what are my obligations to my clients? Nonprofit, alleged grassroots organizations may be a front for a pharmaceutical company. They may obtain most of their funding from such companies. For example "Signs of Suicide" is a program developed by the non-profit group "Screening for Mental Health, Inc." Tax records show that donations from 2001 to 2004 included money from Solvay Pharmaceuticals: $27,500; Pfizer: $750,000; Abbott Laboratories: $235,000; Forest Labs: $153,000; Wyeth Pharmaceuticals: $100,000; and Eli Lilly: $2,157,925 (www.ahrp.org) downloaded. Increasing calls for transparency can be seen in the creation of *Transparency International*. Concerns over conflicts of interests have resulted in medical schools decreasing reliance on pharmaceutical companies in supporting continuing education programs. Calls to ban selling products with bogus claims (Watson, 2008) and to ban support by big pharma are welcome (Tanne, 2008). Health care providers in Vermont received a total of 2.9 million dollars from medical product companies in 2008. Vermont recently passed a law requiring drug and medical device makers to make public all money given to health care providers (Singer, 2009). The philosophy and process of evidence-informed practice, as described in original sources, is designed to weed out bogus claims and involve all parties as informed consumers (Gray, 2001a, 2001b; Straus, Richardson, Glasziou, & Haynes, 2005). It is designed to increase transparency regarding the uncertainty associated with making life-affecting decisions (e.g., DUETs Web site).

We can

- become aware of the power and pervasiveness of propaganda and develop fluency in recognizing indicators of propaganda;
- cultivate and use critical thinking attitudes, knowledge, and skills and keep a log of self-propaganda;
- create and maintain contacts with others who value critical thinking;
- cultivate a resistance to intimidation and blow the whistle on propaganda, fraud, and quackery;
- read primary sources (do not rely on secondary sources) and take advantage of valuable Internet sources such as Alliance for Human Research Protection(www.ahrp.org), www.criticalthinking.org; fallacyfiles.org; healthyskepticism.org,-Innummercy.com; National Council Against Health Fraud; ProCon.org; Skeptic.com; Skeptics Dictionary. Omit overcomingbias.com and veracare;
- find out sources of funding for programs. You maybe surprised;

We can draw on Gricean maximums to decrease self-propaganda as well as to avoid propagandizing others:

Maxim of Quantity: (a) Make your contribution to the conversation as informative as necessary. (b) Do not make your contribution more informative than necessary.
Maxim of Quality: (a) Do not say what you believe to be false. (b) Do not say that for which you lack adequate evidence.
Maxim of Relevance Be relevant (i.e., say things related to the current topic of the conversation).
Maxim of Manner: (a) Avoid obscurity of expression. (b) Avoid ambiguity. (c) Be brief (avoid unnecessary wordiness). (d) Be orderly.

We can keep in mind that in conversations in which seeking the truth is the goal, efforts to avoid or block critical inquiry, so integral to propaganda, are *never* appropriate (Walton, 2008). We can hone our critical thinking skills (Gambrill, 2005; Gambrill & Gibbs, 2009, Gigerenzer, 2002; Hastie & Dawes, 2001; Janis, 1982; Paul & Elder, 2002; Paling, 2006). We can become more aware of self-propaganda such as the illusion of knowledge and certainty and related self-inflated assessments of our competence (Dunning, Heath, & Suls, 2004) that foster uncritical acceptance of propaganda from external sources (see also Cialdini, 2001; Dawes, 2001; Sternberg, 2002). I suggest that being a helping professional, such as a social worker, makes the task of detecting propaganda in the helping profession both more difficult and more easy. It renders it more difficult since the very way problems and resolutions are viewed is deeply influenced by propaganda from a myriad of sources to forward certain views, such as medicalizing more and more common reactions. It is easier in that professionals are ethically bound by their codes of ethics to help their clients and to avoid harm. When taken seriously, these codes give professionals a mandate to raise questions about what is and what is not presented as reality. Propaganda is all about claims about what reality is and what it is not. It means that professionals have an obligation to try as best they can, to peek through the veils of their own ignorance and the framing of certain ways of viewing reality to see if they can get a better glimpse of what is real to clients, what could make their lives better. It means we have an obligation to question our beliefs and fancies. The road that must be traveled is steep with many false paths disguised as promising routes. Need for social reform to help poor children is obscured by promotion of child misbehavior as due to a brain disease.

Conclusion

It is time to pay more attention to propaganda in the helping professions, including related venues such as professional

journals and education programs. Even a cursory examination of media sources and professional literature illustrates that there is a continuing need to remind ourselves about the pervasiveness of propaganda and its effects. As propaganda methods have become more sophisticated, the influence of propaganda is more pervasive and more difficult to resist. Failure to educate social workers as well as other helping professionals about the forms, aims, and consequences of propaganda in the helping professions is a major deficit in professional education today resulting in avoidable harms to clients. Those in the helping professions purport to help clients. Yet we know they often harm instead. One reason for this is failure to draw systematically on related well-argued theory and research and to critically evaluate claims about causes, assessment methods, and proposed remedies. Inter-related kinds of propaganda in the helping professions include deep propaganda that obscures the political, economic, and social contingencies that influence problems claimed by a profession, such as alcohol abuse or social anxiety and the questionable accuracy of related measures and assumptions, for example relabeling problems-in-living as mental disorders that require the help of experts. It includes inflated claims of effectiveness regarding practices and policies that woo clients to professionals and professionals to professions.

The process and philosophy of EBP was developed to help practitioners to evaluate the extent to which claims that have life affecting consequences for clients have been critically tested and to what effect. This should serve as one antidote to propaganda in the helping professions, *if* it includes a critical appraisal of the framing of problems and claims regarding prevalence. Although the increased accessibility of critical appraisal skills programs such as CASP, guidelines for critically appraising different kinds of research reports such as CONSORT and QUORUM, user-friendly books such as *How to read a paper* (Greenhalgh, 2006), and books describing common fallacies (e.g., Gambrill, 2005; Janicek & Hitchcock, 2005) can help professionals to counter influence by propaganda, these do not address sources of propaganda such as the way problems are framed (for example viewing social anxiety as a mental disorder) or bogus estimates of prevalence. Another kind of review is needed for this.

Authors' Note

This article is based on a presentation in honor of Leonard Gibbs, PhD, sponsored by the University of Wisconsin, Madison, April 24, 2009 and by the School of Nursing and the Department of Rehabilitation Psychology and Special Education.

Declaration of Conflicting Interests

The author declared no conflicts of interest with respect to the authorship and/or publication of this article.

Funding

The author thanks the Hutto Patterson Chair funders for support.

References

Abramowitz, M. (1988). *Regulating the lives of women: Social welfare policy from colonial times to the present.* Boston: South End Press.

Altheide, D. L., & Johnson, J. M. (1980). *Bureaucratic propaganda.* Boston: Allyn & Bacon.

Altman, D. G. (2002). Poor-quality medical research: What can journals do? *Journal of the 41-American Medical Association*, *287*, 2765-2767.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association, News Release. (2009, February 25). *The American Psychiatric Association Phases Out Industry-Supported Symposia.* Arlington, VA.

Angell, M. (2005). *The truth about drug companies: How they deceive us and what to do about it.* New York: Random House. (Revised and updated).

Angell, M. (2008). Industry sponsored clinical research: A broken system. *Journal of the American Medical Association*, *300*, 1069-1071.

Angell, M. (2009). Drug companies & doctors: A story of corruption. *New York Review of Books*, 1/15.

Antonuccio, D. O., Burns, D. D., & Danton, W. G. (2002). Antidepressants: A triumph of marketing over science. *Prevention & Treatment, 5* (Article 25). Posted July 15, 2002.

Antonuccio, D. O., & Healy, D. (2009). (Letter). Stealth advertising and academic stalking. *British Medical Journal*, *338*, 968.

Barkley, R. A., Cook, E. H., Diamond, A., Zametkin, A., Thapar, A., Teeter, A., et al. (2002). International Consensus Statement on ADHD. *Clinical Child and Family Psychology Review*, *5*, 89-111.

Bass, A. (2008). *Side effects: A prosecutor, a whistleblower, and a bestselling antidepressant on trial.* Chapel Hill, NC: Algonquin Books.

Bauer, H. (2001). *Fatal attractions: The troubles with science.* New York: Paraview Press.

Baughman, F. A., & Hovey, C. (2006). *The ADHD fraud: How psychiatry makes "patients" of normal children.* Victoria, BC: Trafford.

Bausell, R. B. (2007). *Snake oil science: The truth about complementary and alternative medicine.* New York: Oxford.

Bennett, B. S., & O'Rourke, S. P. (2006). A prolegomenon to the future study of rhetoric and propaganda. In G. S. Jowett & V. O'Donnell (Eds.), *Readings in propaganda and persuasion: New and Classic essays* (pp. 51-71). Thousand Oaks, CA: SAGE.

Bernays, E. L. (1923). *Crystallizing public opinion.* New York: Boni & Liveright.

Bernays, E. L. (1928). *Propaganda.* New York: Liveright.

Best, J. (2001). *Dammed lies & statistics: Untangling numbers from the media, politicians & activists.* Berkeley: University of California Press.

Boynton, P. M., Shaw, S., & Callaghan, W. (2004). How PR firms use research to sell products. *British Medical Journal*, *28*, 530.

Boyle, M. (2002). *Schizophrenia: A scientific definition?* (2nd ed.). London: Routledge.

Braddock, C. H., Edwards, K. A., Hasenberg, N. M., Laidley, T. L., & Levinson, W. (1999). Informed decision making in outpatient

practice. Time to get back to basics. *Journal of the American Medical Association*, *282*, 2313-2320.

Brody, H. (2007). *Hooked: Ethics, the medical profession and pharmaceutical industry.* New York: Rowman & Littlefield.

Brown, P., & Funk, S. C. (1986). Tardive dyskinesia: Barriers to the professional recognition of an iatrogenic disease. *Journal of Health & Social Behavior*, *27*, 116-132.

Busch, R. S. (2008). *Healthcare fraud: Auditing and detection guide.* Hoboken, NJ: John Wiley & Sons.

Caplan, P. J. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide what's normal.* Reading, MA: Addison-Wesley.

Caplan, P. J., & Cosgrove, L. (2004). *Bias in psychiatric diagnosis.* Lanhan: Jason Aronson.

Carey, B. & Harris, G. (2008). Psychiatric Association Faces Senate Scrutiny over drug industry ties. *New York Times*, 7/12/078, A 13.

Chalmers, I. (1983). Scientific inquiry and authoritarianism in perinatal care and education. *Birth*, *10*, 151-166.

Cialdini, R. B. (2009). *Influence: Science and practice* (5th ed.). Pearson education.

Combs, J. E., & Nimmo, D. (1993). *The new propaganda: The dictatorship of palaver in contemporary politics.* New York: Longman.

Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders.* Baltimore, MD: John Hopkins University Press.

Cosgrove, L., Bursztajn, H. J., Krimsky, S., Anaya, M., & Walker, J. (2009). Conflicts of interest and disclosure in the American Psychiatric Association's clinical practice guidelines. *Psychotherapy and Psychosomatics*, *78*, 228-232.

Cunningham, S. B. (2002). *The idea of propaganda: A reconstruction.* Westport, CT: Praeger.

Damer, T. E. (2005). *Attacking faulty reasoning: A practical guide to fallacy-free arguments* (3rd ed.). Belmont, CA: Wadsworth.

Dawes, R. M. (2001). *Everyday irrationality: How pseudoscientists, lunatics and the rest of us systematically fail to think rationally.* Boulder, CO: Westview Press.

Double, D. B. (2006). *Critical psychiatry: The limits of madness.* New York: Palgrave.

Dunning, D., Heath, C., & Suls, J. M. (2004). Flawed self-assessment. Implications for health, education and the work place. *Psychological Science in the Public Interest*, *5*, 69-106.

El-hai, J. (2005). *The lobotomist: A maverick medical genius and his tragic guest to rid the world of mental illness.* Hoboken, NJ: John Wiley & Sons.

Elliott, D., & Chambers, T. (Eds.). (2004). *Prozac as a way of life.* Chapel Hill: University of North Carolina Press.

Ellul, J. (1964). *The technological society.* New York: Vintage Books.

Ellul, J. (1965). *Propaganda: The formation of men's attitudes.* New York: Vintage.

Engel, S. M. (1994). *With good reason: An introduction to informal fallacies* (5th ed.). New York: St. Martin's Press.

Evans, I., Thornton, H., & Chalmers, J. (2006). *Testing treatments: Better research for better healthcare.* London: The British Library.

Florini, A. (Ed.). (2007). *The right to know: Transparency for an open world.* New York: Columbia.

Frankfurt, H. G. (1986). On bullshit. *Raritan*, *6*, 81-100.

Frankfurt, H. G. (2005). *On bullshit.* Princeton University Press.

Freire, P. (1973). *Education for critical consciousness.* New York: Continuum.

Frosch, D. L., Krueger, P. M., Hornik, R. C., Cronholm, P. F., & Barg, F. K. (2007). Creating demand for prescription drugs: A content analysis of television direct-to-consumer advertising. *Annals of Family Medicine*, *5*, 6-13.

Gambrill, E. (1997). Social work education: Possible futures. In M. Reisch & E. Gambrill (Eds.), *Social work in the 21st century* (pp. 317-327). Thousand Oaks, CA: Pine Forge Press.

Gambrill, E. (2005). *Critical thinking in clinical practice: Improving the quality of judgments and decisions* (2nd ed.). New York: John Wiley.

Gambrill, E. (2006). Evidence-based practice: Choices ahead. *Research on Social Work Practice*, *16*, 338-357.

Gambrill, E., & Gibbs, L. E. (2009). *Critical thinking for the helping professions: A skills-based workbook* (3rd ed.). New York: Oxford University Press.

Gandhi, A. G., Murphy-Graham, E., Petrosino, A., Chrismer, S. S., & Weiss, C. H. (2007). The devil is in the details. *Evaluation Review*, *31*, 43-74.

Gibbs, L., & Gambrill, E. (2002). Evidence-based practice: Counterarguments to objections. *Research on Social Work Practice*, *12*, 452-476.

Gigerenzer, G. (2002). *Calculated risks: how to know when numbers deceive you.* New York: Simon & Schuster.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates.* New York: Doubleday.

Gorman, D. M., & Huber, J. C. (2009). The social construction of "evidence-based" drug prevention programs: A reanalysis of data from the Drug Abuse Resistance Education (DARE) Program. *Evaluation Review*, *33*, 396-414.

Gornall, J. (2009). Industry attack on academics. *British Medical Journal*, *338*, b736.

Gøtzsche, P. C., Hartling, O. J., Nielsen, M., Brodersen, J., & Jørgensen, K. J. (2009). Analysis: Breast screening: The facts or maybe not. *British Medical Journal*, *338*:b86.

Gray, J. A. M. (2001a). Evidence-based medicine for professionals. In A. Edwards & G. Elwyn (Eds.), *Evidence-based patient choice: Inevitable or impossible?* (pp. 19-33). New York: Oxford University Press.

Gray, J. A. M. (2001b). *Evidence-based health care: How to make health policy and management decisions.* New York: Churchill Livingston.

Greenhalgh, T. (2006). *How to read a paper: The basics of evidence-based medicine* (3rd ed.). London: BMJ Press.

Hadler, N. M. (2004). *The last well person: How to stay well despite the health-care system.* Ithaca: McGill-Queen's University Press.

Harris, G. (2004). At F. D. A., strong drug ties and less marketing. *New York Times*, 12/6/04.

Harris, G. (2009, October 22). Drug makers are advocacy group's biggest donors. *The New York Times*.

Harris, G., & Carey, B. (2008, June 8). Researchers fail to reveal full drug pay. *New York Times*.

Hastie, R., & Dawes, R. (2001). *Rational choice in an uncertain world: The psychology of judgment and decision making.* Thousand Oaks, CA: SAGE.

Healy, D. (2004). *Let them eat Prozac: The unhealthy relationship between the pharmaceutical industry and depression.* New York: New York University Press.

Hilgartner, S. (2000). *Science on stage: Expert advice as public drama.* CA: Stanford University Press.

Horowitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder.* New York: Oxford University Press.

Illich, I. (1976). *Medical nemesis: The expropriation of health.* New York: Random House.

Illouz, E. (2008). *Saving the modern soul: Therapy, emotions, and the culture of self-help.* Berkeley: University of California Press.

Ioannidis, J. P. A. (2005). Why most published research findings are false. *PLoS Medicine*, *2*, e124.

Jacobson, J. W., Foxx., R. M. & Mulick, J. A. (Eds.). (2005). *Controversial therapies for developmental disabilities: Fad, fashion, and science in professional practice.* Mahwah, NJ: Erlbaum.

Janicek, M., & Hitchcock, D. L. (2005). *Evidence-based practice: Logic and critical thinking in medicine.* Chicago: American Medical Association.

Janis, I. L. (1982). *Groupthink: Psychological studies of policy, decisions and fiascos* (2nd ed.). Boston: Houghton Mifflin.

Jarvis, W. T. (1990). *Dubious dentistry: A dental continuing education course.* Loma Linda, CA: Loma Linda University School of Dentistry.

Jørgensen, K. J., & Gøtzsche, P. C. (2004). Presentation on websites of possible benefits and harms from screening for breast cancer. Cross sectional study. *British Medical Journal*, *328*, 148-155.

Jowett, G., & O'Donnell, V. (2006). *Propaganda and persuasion* (4th ed.). Thousand Oaks, CA: SAGE.

Kassirer, J. P. (2005). *On the take: How medicine's complicity with big business can endanger your health.* New York: Oxford University Press.

Katz, M. B. (1989). *The undeserving poor: From the war on poverty to the war on welfare.* New York: Pantheon.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, *62*, 612-627.

Kirk, S. A. (2004). Are children's DSM diagnoses accurate? *Brief Treatment and Crisis Intervention*, *4*, 255-270.

Kluger, M. P., Alexander, G., & Curtis, P. A. (2002). *What works in child welfare.* Washington, DC: CWLA Press.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (2000). *To err is human: Building a safer health system.* Washington, DC: National Academy Press.

Krimsky, S. (2003). *Science in the private interest: Has the lore of profits corrupted biomedical research?* Lanham, MD: Rowman and Littlefield.

Kutchins, H., & Kirk, S. A. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders.* New York: Free Press.

LaCasse, J. R., & Gomory, T. (2003). Is graduate social work education promoting a critical approach to mental health practice? *Journal of Social Work Education*, *39*, 383-408.

LaCasse, J. R., & Leo, J. (2005). Serotonin and depression: A disconnect between the advertisements and the scientific literature. *PLoS Medicine*, *2*, e392.

Lane, C. (2007). *Shyness: How normal behavior became a sickness.* New Haven: Yale University Press.

Larson, M. S. (1977). *The rise of professionalism: A sociological analysis.* Berkeley: University of California Press.

Lazarou, J., Pomeranz, B. H., & Corey, P. N. (1998). Incidence of adverse drug reactions in hospitalized patients: A meta-analysis and prospective study. *Journal of the American Medical Association*, *279*, 1200-1205.

Leape, L. L., & Berwick, D. M. (2005). Five years after *To Err Is Human*: What have we learned? *Journal of the American Medical Association*, *293*, 2384-2390.

Leo, J. (2009). *JAMA*, free speech, and conflicts of interest. *Society*, *46*, 472-476.

Lenzer, J. (2004). Secret US report surfaces on antidepressants in children. *British Medical Journal*, 329, 307.

Leo, J., & Cohen, D. (2003). Broken brains or flawed studies? A critical review of ADHD Neuroimaging research. *Journal of Mind and Behavior*, *24*, 29-56.

Leo, J., & LaCasse, T. (2009). (Letter) Clinical trials of therapy versus medication: Even in a tie, Medication wins. *British Medical Journal*, *March 5, 2009*.

Lilienfeld, S. O., Lynn, S. J., & Lohr, J. M. (2003). *Science and pseudoscience in clinical psychology.* New York: Guilford.

Littell, J. H. (2005). Lessons from a systematic review of effects of multisystemic therapy. *Children and Youth Services Review*, *27*, 445.

Littell, J. H. (2006). The case for multisystemic therapy: Evidence or orthodoxy? *Children and Youth Services Review*, *28*, 458-472.

Lo, B., & Field, M. J. (Eds.). (2009). *Conflict of interest in medial research, education and practice. Institute of Medicine.* Washington, DC: National Academy Press.

Lock, S., Wells, F., & Farthing, M. (2001). *Fraud and misconduct in biomedical research* (3rd ed.). London: BMJ Books.

Loeske, D. R. (1999). *Thinking about social problems: An introduction to constructionist perspectives.* New York: Aldine de Gruyter.

Lumley, F. E. (1933). *The propaganda menace.* New York: Century Co.

MacCoun, R. (1998). Biases in the interpretation and use of research results. *Annual Review of Psychology*, *49*, 259-287.

Marchand, R. (1985). *Advertising the American dream: Making way for modernity 1920:1940.* Berkeley: University of California Press.

Margolin, L. (1997). *Under the cover of kindness: The invention of social work.* Charlottesville: University of Virginia Press.

McCabe, D. P., & Castel, A. D. (2008). Seeing is believing: The effect of brain images on judgment of scientific reasoning. *Cognition*, *107*, 343-352.

McCoy, R. (2000). *Quack*! *Tales of medical fraud from the museum of questionable medical devices.* CA: Santa Monica Press.

McLuhan, M. (1951). *The mechanical bride: Folklore of industrial man.* Boston: Beacon Press.

Medawar, C., & Hardon, A. (2004). *Medicines out of control? Antidepressants and the conspiracy of goodwill.* The Netherlands: Aksant.

Midanik, L. (2006). *Ideological shifts and institutional challenges. The biomedicalization of alcohol studies.* New Brunswick, NJ: Aldine/Transaction.

Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment.* New York: Palgrave.

Moynihan, R. (2003). The making of a disease: Female sexual dysfunction. *British Medical Journal*, *326*, 45-47.

Moynihan, R. (2009). News. Court hears how drug giant Merck tried to "neutralize" and "discredit" doctors critical of Vioxx. *British Medical Journal*, *338:b1432*.

Moynihan, R., & Cassels, A. (2005). *Selling sickness: How the world's biggest pharmaceutical companies are turning us all into patients.* New York: Nation Books.

Narrow, W. E., Rae, D. S., Robins, L. N., & Regier, D. A. (2002). Revised prevalence estimates of mental disorders in the United States: Using a clinical significance criterion to reconcile 2 surveys' estimates. *Archives of General Psychiatry*, *59*, 115-123.

Nathan, P. E., & Gorman, J. M. (2007). *A guide to treatments that work* (3rd ed.). New York: Oxford University Press.

Norcross, J. C., Beutler, L. E. & Levant, R. F. (Eds.). (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions.* Washington, DC: American Psychological Association.

Paling, J. (2006). *Helping patients understand risks: 7 simple strategies for successful communication.* Gainsville, FL: The Risk Communication Institute.

Patton, B. M. (2000). *Truth, knowledge or just plain bull: How to tell the difference.* Amherst, NY: Prometheus.

Paul, R. W., & Elder, L. (2002). *Critical thinking: Tools for taking charge of your professional and personal life.* Upper Saddle River, NJ: Prentice Hall.

Paul, R. W., Elder, L., & Bartell, J. (1997, March). *California teacher preparation for instruction in critical thinking: Research findings and policy recommendations.* Sacramento, CA: California Commission on Teacher Credentialing.

Payer, L. (1992). *Disease mongers: How doctors, drug companies, and insurers are making you feel sick.* New York: John Wiley & Sons.

Petersen, M. (2008). *Our daily meds: How the pharmaceutical companies transformed themselves into slick marketing machines and hooked the nation on prescription drugs.* New York: Picador.

Petrosino, A., Turpin-Petrosino, C., & Finckenauer, J. O. (2000). Well-meaning programs can have harmful effects! Lessons from experiments of programs such as Scared Straight. *Crime & Delinquency*, *46*, 354-379.

Pfohl, S. (1994). *Images of deviance and social control: A sociological history* (2nd ed.). New York: McGraw Hill.

Porter, R. (2000). *Quacks: Fakers & charlatans in English medicine.* Charleston, SC: Tempus.

Pratkanis, A. R., & Aronson, E. (2001). *Age of propaganda: The everyday use and abuse of persuasion* (Revised Edition). New York: Owl Books.

Proctor, R. N., & Schiebinger, L. (Eds.). (2008). *Agnotology: The making and unmaking of ignorance.* Palo Alto, CA: Stanford University Press.

Prounis, C. (2004). The art of advertorial. *Pharmaceutical Executive*, *24*, 152-159.

Rabin, R. C. (2009, March 31). Benefits of mammogram under debate in Britain. *New York Times*.

Rank, H. (1994). *The pep talk: How to analyze political language.* Park Forest, IL: Counter-Propaganda Press.

Renner, C. H. (2004). Validity effect. In R. F. Pohl (Ed.), *Cognitive illusions: A handbook on fallacies and biases in thinking, judgment and memory* (pp. 201-213). New York: Psychology Press.

Rothman, D. J., McDonald, W. J., Berkowitz, C. D., Chimonas, S. C., DeAngelis, C. D., Hale, R., et al. (2009). Professional medical associations and their relationships with industry. *The Journal of the American Medical Association*, *301*, 1367-1372.

Routzahn, M. S. (1920). *Traveling publicity campaigns.* New York: Russell SAGE Foundation.

Rubin, A., & Parrish, D. (2007). Problematic phrases in the conclusions of published outcome studies: Implications for evidence-based practice. *Research on Social Work Practice*, *17*, 592-602.

Sackett, D. L., Richardson, W. S., Rosesnberg, W., & Haynes, R. B. (1997). *Evidence-based medicine: How to practice and teach EBM.* New York: Churchill Livingston.

Scull, A. (2005). *Madhouse: A tragic role of megalomania and modern medicine.* New Haven, CT: Yale University Press.

Sharpe, V. A., & Faden, A. I. (1998). *Medical harm: Historical, conceptual, and ethical dimensions of iatrogenic illness.* New York: Cambridge University Press.

Singer, N. (2009). Doctor gifts to be public in Vermont. *New York Times*, 5/20, B1/10.

Skinner, B. F. (1953). *Science and human behavior.* New York: Macmillan.

Skrabanek, P., & McCormick, J. (1998). *Follies and fallacies in medicine* (3rd ed.). Whithorn: Tarragon Press.

Smith, R. (2006). Peer review: A flawed process at the heart of science and journals. *Journal of the Royal Society of Medicine*, *99*, 178-182.

Sparrow, M. K. (2000). *License to steal: How fraud bleeds America's health care system.* Boulder, CO: Westview.

Stein, R. (2007). Doctor says Avandia makers intimated him. *The Washington Post*, 6/7, p. A06.

Sternberg, R. J. (Ed.). (2002). *Why smart people can be so stupid.* New Haven: Yale University Press.

Straus, S. E., Richardson, W. C, Glasziou, P., & Haynes, R. B. (2005). *Evidence-based medicine: How to practice and teach EBM* (3rd ed.). New York: Churchill Livingstone.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal*, *322*, 95-98.

Summerfield, D. (2002). Selling sickness: The pharmaceutical industry and disease mongering. *British Medical Journal*, *324*, 914.

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *British Medical Journal*, *336*, 992-994.

Sweeney, H. M. (1997). Twenty-five ways to suppress truth: The rules of disinformation.

Szasz, T. S. (1987). *Insanity: The idea and its consequences.* New York: John Wiley.

Szasz, T. S. (1994). *Cruel compassion: Psychiatric control of society's unwanted.* New York: John Wiley.

Tanne, J. H. (2008). US medical schools should say no to pharma support. *British Medical Journal*, *336*, 1035.

Tice, K. W. (1998). *Tales of wayward girls and immoral women: Case records and the professionalization of social work.* Urbana: University of Illinois Press.

Timini, S. (2002). *Pathological child psychiatry and the medicalization of childhood.* London: Brunner/Routledge.

Transformative Neurodevelopmental Research in Mental Illness. (2008). Report of the National Advisory Mental Health Council's Workgroup on neurodevelopment distributed at Conference on Adolescent Psychopathology. Madison, WI, April 2009.

Tuffs, A. (2004). Only 6% of drug advertising material is supported by evidence. *British Medical Journal*, *328*, 485.

Tufte, E. (2007). *Beautiful evidence.* Cheshire, CT: Graphics Press.

Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., & Rosenthal, R. (2008). Selective publications of antidepressant trials and its influence on apparent efficacy. *The New England Journal of Medicine*, *358*, 252-260.

Valenstein, E. S. (1986). *Great and desperate cures: The rise and decline of psychosurgery and other radical treatments for mental illness.* New York: Perseus Books.

Vul, E., Harris, C., Winkielman, P., & Pashler, H. (2009). Puzzlingly high correlations in fMRI studies of emotion, personality and social cognition. *Perspectives on Psychological Science*, *4*, 274-290.

Walton, D. (2008). *Informal logic: A pragmatic approach* (2nd ed.). New York: Cambridge University Press.

Watson, R. (2008). New law bans selling of products with unjustified health claims. *British Medical Journal*, *336*, 1150.

Wampold, B. E., Imel, Z. E., & Miller, S. D. (2009). Barriers to the dissemination of empirically supported treatments: Matching messages to the evidence. *The Behavior Therapist*, *10*, 144-155.

Welch, H. G. (2004). *Should I be tested for cancer? maybe not and here's why.* Berkeley: University of California Press.

Wilkes, M. S., & Hoffman, J. R. (2001). An innovative approach to educating medical students about pharmaceutical promotion. *Academic Medicine*, *76*, 1271-1277.

Williamson, J. (2002). *Decoding advertisements: Ideology and meaning in advertising.* New York: Marion Boyars.

Winocur, M., Holtan, A., & Valentine, D. (2008). Kinship care for the safety, permanency and well-being of children removed from the home for maltreatment. CC_1 and CC_2 Systematic Review (co-registered).

Wofford, J. L., & Ohl, C. A. (2005). Teaching appropriate interactions with pharmaceutical company representatives: The impact of an innovative workshop on students attitudes. *BMC Medical Education*, *5*, 5.

Young, J. H. (1992). *American health quackery.* Princeton, NJ: Prentice University Press.