Applying psychological and psychiatric insights

to innovate the practice of executive consulting

while also contributing to the further development

of the psychological and psychiatric practices

by using cases and experience,

anchored in academic theory

Production for acquiring the grade of PhD

related to psychology and psychiatry

Final part (synthesizing and newforming)

Swiss School of Business Research

Antoon Berendsen (16 February 1961)

Version date 3 August 2024 (final version) **Confidential**

TABLE OF CONTENT

LIST OF TABLES

LIST OF FIGURES

LIST OF ENCLOSURES

3.0. THE INTRODUCTION

3.0.0. The overall introductions

The aspiration is to deliver a production for obtaining the grade of PhD. This is realized by applying psychological and psychiatric insights (hereafter the terms “psychological” and “psychiatric” are combined under the umbrella term “mental”) to innovate the practice of executive consulting, while also contributing to the further development of mental consulting. Apart from the academic requirements, this production is based on the ambitions as well as the presented cases and the professional practice of the author, including pre existing research, comprehensive research skills and extensive subject knowledge of the author.

The author holds a master’s degree, specializing in psychology, completed a master’s program in the field of psychiatry with distinction and concluded a post-doc in innovation management. This combined with some 40 years experience in both executive and mental consulting provides a sound foundation for fulfilling the PhD aspirations.

Over the years, in the diagnosis of executive and mental consulting, the author experienced many shortcomings and explored many solutions as presented in earlier sections. This production capitalizes on these experiences, and presents a synthesis, among others based on the earlier presented shortcomings regarding executive and mental consulting from the first module, combined with the earlier presented ideas from the second module, among others regarding problem solving in executive and mental consulting.

The developed and presented diagnostics are innovative, given that in the diagnosis of executive consulting no practice based guidance is available for approaching (i) the adequacy of senior leadership and (ii) corporate strategy as well as for approaching (iii) the potential for atypical leadership tendencies and (iv) the foreseeable resistances. Likewise, (v) the developed hypothesis about the etiology of mental disorders and (vi) the developed hypothesis about the nosology of mental disorders provide disruptive and thought-provoking insights.

The combination of these developed innovations presents a coherent and practical foundation for executive and mental consulting, to be applied situationally and eclectically. Furthermore, state-of-the-art knowledge and authority of the author are demonstrated in terms of redefining the professional diagnostic practices of executive and mental consulting. However, it should be considered that supportives can never replace the expertise plus experience of consultants.

In executive consulting, the role of mental consulting cannot easily be overestimated. For instance, atypical behavioral tendencies of senior leadership will often prove to have damaging effects on for instance the corporate strategy as well as on the team functioning and the organizational culture, even to the extent that it may jeopardize the continuity of organizations.

The atypical behavioral tendencies have already been defined in earlier productions, but in short, they are behaviors that deviate from what may be expected in certain situations. Behavior from senior leadership that deviates significantly from what may be expected, often relates to personality disorders as well as to the milder forms of mental disorders, also linking mental consulting to executive consulting. Likewise, biases as well as defenses and resistances anchored in psychology and psychiatry is also closely related to executive consulting.

However, bringing psychology and psychiatry for good reasons in scope of executive consulting, brings many considerations about integrity and ethics as well as skills and experience as clarified in earlier sections. For instance, obtaining an expert level in a profession requires roughly 10 years of experience, equaling some 18,000 hours (Ericsson, Krampe and Tesch-Romer, 1993).

To illustrate the relevance of mental consulting in executive consulting, it may for instance be the case that senior leadership practices a leadership style that best suits their atypical behavioral tendencies, instead of adapting the style that is required in the specific situation. The in earlier sections presented cases regarding these atypical leadership tendencies of senior leadership cover grandioseness, fearfulness and somberness.

Following the relevance of mental consulting for executive consulting, it may be the case that senior leadership formulates and executes a strategy that best suits their atypical behavioral tendencies, instead of formulating and executing the strategy that should be chosen. Some examples of the consequences of these atypical leadership tendencies may for instance be overly expansive strategies in cases of grandioseness, overly cautious strategies in cases of fearfulness or overly defensive strategies in cases of somberness. It needs no extensive explanation that these strategies of senior leadership will destroy value and will jeopardize the legitimate interests of stakeholders, and even the continuity of organizations.

3.0.1. The definitions in this production

In this section, the term “author” is exclusively used for the writer of this production. Regarding the positioning of psychology and psychiatry, the following.

Stereotypically, psychological consulting relates more to behavior, and is typically mind related, while psychiatric consulting relates more to illnesses, and is typically more brain circuitry related. However, this dichotomy is subject to ongoing debates (e.g., Thagard, 2021).

In terms of the author, “executive consulting” is defined as providing advice exclusively to senior leadership, thus to C-level board members. Some discriminating characteristics of executive consulting versus management consulting are the one-on-one oral interactions with real time interventions and the narrow relationships with mental consulting.

To be as brief and structured as possible, and to prevent unnecessary long arrays of text, tables are used where appropriate. All data in the tables are from the author, unless stated otherwise.

Given that the professional expertise and the experience of the author are central in this production, literature references are kept to a minimum, while honoring intellectual property. At the same time, the author believes that older literature from which often many other publications are derived, should not be brushed aside too soon, and should receive the attention it deserves.

3.0.2. The initial considerations about innovation

The term “innovation” is used in many different ways. The word innovation stems from the verb “innovare”, Latin for introducing new. However, in the informed opinion of the author, innovations do not necessarily have to be objectively new (Berendsen, 1991), as is the case with inventions. This implies that an innovation may also involve transferring ideas or solutions from one domain to another domain as well as forming new combinations of the existing. In this production, the developed innovations are visualized in the following figure.

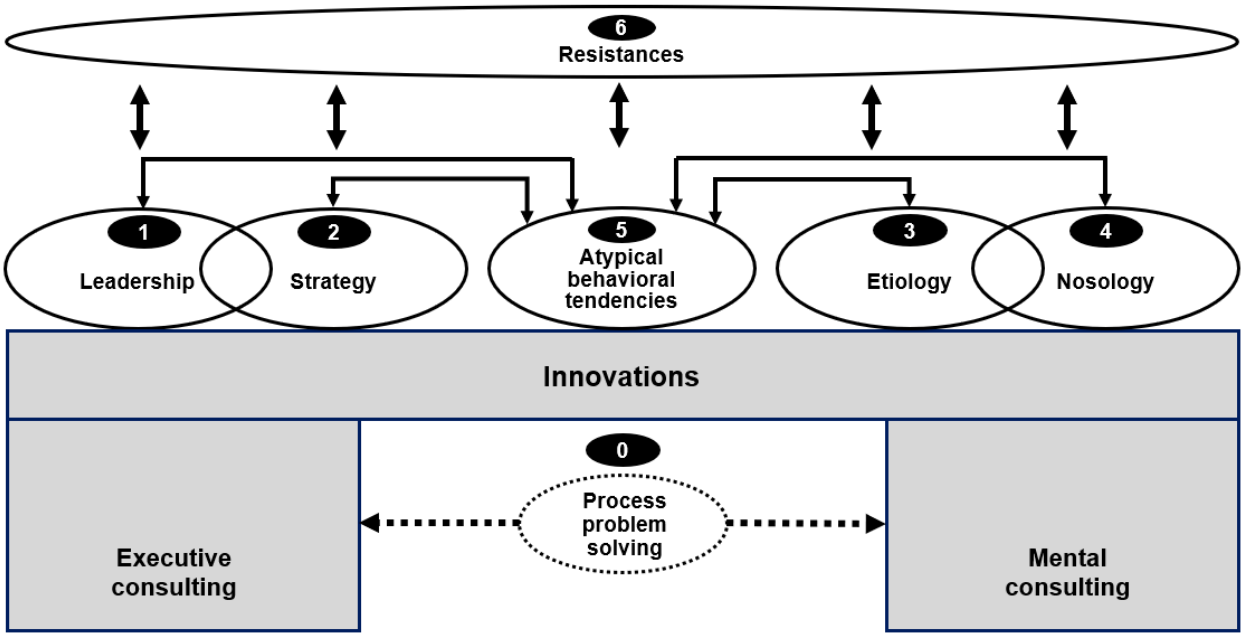

Figure 1 - the schematic representation of the innovations

The first innovation concerns a new process (0) for problem solving in executive consulting, including important recommendations for the process of mental consulting. This process was already presented in an earlier production, and is added in the enclosure for convenience.

For executive consulting, the innovations concern the development of diagnostics for approaching the adequacy of leadership (1) and strategy (2). For mental consulting, the innovations concern the development of a hypothesis about the etiology of mental disorders (3) and a framework for the nosology of mental disorders (4). Furthermore, the combined innovations for executive and mental consulting concern the development of a diagnostic for approaching the foreseeable atypical behavioral tendencies (5) and the development of a diagnostic for approaching the potential for resistances (6).

It should be noted that the newly developed and innovative process for problem solving (please, refer to the enclosures 1 through 8) is applicable for both executive and mental consulting.

Regarding innovation, most contributions are about innovating organizations (e.g., McKinsey, 2024a; Harvard Business Review, 2024) and not about innovating professional practices. However, some contributions are more generic, also related to professional practices. For instance, a podcast by Harvard Business Review, based on a book about transformation (Anthony, 2017) stresses that innovation is hard, while requiring courage, clarity, curiosity and conviction. Research by McKinsey (De Jong, Marston and Roth, 2015) elaborates on the eight essentials of innovation: Aspire, choose, discover, evolve, accelerate, scale, extend and mobilize. Other research by McKinsey (Cohen, Quinn and Roth, 2019) emphasizes the need for setting bold aspirations, making tough choices, and mobilizing resources at scale.

At the same time, rapidly accelerating and ongoing demands on organizations, also triggered by requirements stemming from for instance sustainability (e.g., McKinsey, 2024b) and artificial intelligence (e.g., Singla et al., 2024; Hazan et al., 2024), puts continuous and heavy claims on senior leadership, reinforced by increasing and diverse requirements of stakeholders.

Comprehensive research by BCG (Lesser, 2024) clarifies that these accelerating demands make changes in the form of improvements no longer sufficient, implying that senior leadership has to innovate, and thus has to transform themselves and their organizations. This puts even more pressure on senior leadership, inducing stress, and foreseeably contributing to atypical behavioral tendencies or even mild forms of mental disorders.

Furthermore, organizational development requires paradigm shifts in leadership (Greiner, 1972). At the same time, it can not be expected from senior leadership to keep reinventing itself limitless, giving rise to the need of sometimes having to replace senior leadership.

However, nearly 90 percent of all organizational transformations do not realize the planned and required effects as researched by Bain (Slagt, Burke and Cochemé, 2024). Likewise, in the experience of the author, the effects of trying to change the behavior of senior leadership may not always be successful as well, among others given their strong personalities. According to the author, the lacking of practice based diagnostics for approaching the situational adequacy of senior leadership and corporate strategy as well as the absence of diagnostics for approaching the potential for atypical behavioral tendencies and the foreseeable resistances will contribute to these failures. This emphasizes the relevance for these diagnostics again.

Given these considerations and to summarize, fresh and new ideas need to be developed to facilitate effective problem solving in executive and mental consulting. To begin, this requires innovative diagnostics. After all, one sided building on the existing bears the foreseeable risk of delivering roughly more of the same, resulting in only incremental improvements or even repetitions of arguments and moves. This may prevent innovations in terms of breakthroughs stemming from challenging existing paradigms and convictions (Berendsen, 1991).

To realize an innovative diagnostic for the adequacy of senior leadership and corporate strategy, over the years, a rich and practice derived assortment of questions and norms has been acquired by the author. An extensive set of diagnostics, instead of a limited set of questions helps to overcome the risks of biases slipping in, including tunnel visions. Regarding biases, one of the major causes of biases in diagnostic processes is overreliance on automatic heuristics stemming from the fast working system one (Kahneman, 2012), often resulting in misdiagnoses, and ultimately in erroneous results.

3.1. THE INNOVATIONS FOR EXECUTIVE CONSULTING

3.1.0. The introduction regarding executive consulting

The core of executive consulting relates to senior leadership and corporate strategy as presented in the black ovals, numbered 1 and 2 in the figure below. As argued earlier, executive consulting is missing (practice based) diagnostics to approach the adequacy of both senior leadership and corporate strategy, or these diagnostics are proprietary and thus not publicly available. The term "approach" is used to emphasize that executive consultancy is exclusively aimed at acquiring an informed opinion about the situational adequacy of senior leadership and corporate strategy.

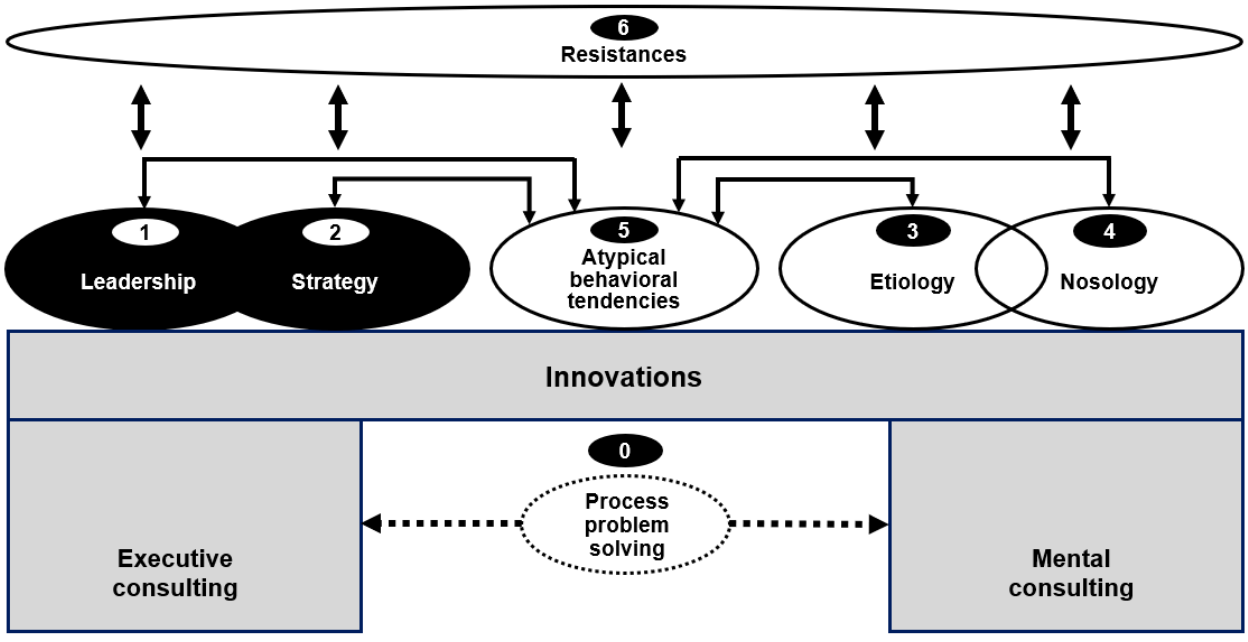

Figure 2 - the innovations in executive consulting

3.1.1. The diagnostic for approaching adequacy of senior leadership

This developed innovative diagnostic facilitates the solving of one of the most critical business problems as argued earlier, the situational adequacy of senior leadership. This innovative diagnostic is practice based and presents state-of-the-art knowledge by integrating actual insights, and presents authority by contributing to the redefinition of the professional practice of executive consulting. The diagnostic is synthesized from some 40 years of acquired and consolidated experience of the author in executive and mental consulting, and is based on the questions that have been proven to be the most productive over the years.

The objective of the presented questions is to obtain a coherent and informed opinion about the situational adequacy of senior leadership. This opinion has been formed by intensive interactions with senior leadership, typically during half a day each. As explained earlier, the concept of executive consulting is about raising questions, listening actively, observing reactions and challenging responses, while weighing and integrating the answers of rich sets of questions to form a fair and unbiased representation. Approaching the adequacy of senior leadership requires seasoned and skilled executive consultants, while also requiring prudence, among others given considerations around integrity.

In cases in which the leadership style of senior leadership and their teams, and even the culture of organizations should be evaluated instead of approached, the Disc framework (Disc, 2023; Disc, n.d.) is considered suitable, given the reliability and the validity of these frameworks as presented in earlier productions.

Also, organizations develop according to predictable patterns (Greiner, 1972). These patterns are characterized by phases of relative stability, followed by crises. Each phase has different strategic emphases, also requiring different senior leadership styles. Coping with these crises requires specialized leadership skills (e.g., Berendsen and Segers, 2020). One of the considerations is to what extent senior leadership is able to keep reinventing itself. Not being able to reinvent itself may also be the reason that organizations have a relatively short average life (Statista, 2024).

In the following table, based on the research of Greiner (Greiner, 1972), the required changes in senior leadership styles are stereotyped. An executive consultant may approach the current phase of the organization, and advise about anticipating another senior leadership style required for the succeeding phase of organizational development. However, it should be noted that this is an ideal typical model of reality, thus due care should be practiced in preventing reification.

Table 1 - the changes in leadership in organizational development

CRISIS	CRISIS CAUSED BY	REQUIRED CHANGE
Not applicable	Creativity	Visioning
Too little leadership	Leadership missing	Formalizing
Too little autonomy	Leadership too centralized	Delegating
Too little control	Leadership too loose	Coordinating
Too much bureaucracy	Leadership too controlling	Collaborating
Too much consultation	Leadership too consensual	Directing
Too little identity	Leadership too hard-sided	Humanizing
Too little accountability	Leadership too soft-sided	Owning
Too little trust	Leadership too paranoid	Trusting

Furthermore, an article by McKinsey (De Smet et al., 2023) defines five fundamental and innovative shifts in senior leadership, which should also be taken into consideration when approaching the adequacy of senior leadership in terms of the extent to which senior leadership presents or prepares for these shifts.

Table 2 - the fundamental shifts in leadership

The fundamental shifts in leadership
The shift from a manager delivering profits to shareholders with a mindset of preservation to a visionary generating holistic impact for all stakeholders with a mindset of possibility.
The shift from a planner competing for existing value with a mindset of scarcity to an architect cocreating value through reimagining with a mindset of abundance.
The shift from a director commanding through hierarchy with a mindset of authority to a catalyst collaborating in empowered networks with a mindset of partnership.
The shift from a controller administrating through detailed predictions with a mindset of certainty to a coach evolving through rapid learning with a mindset of discovery.
The shift from a professional meeting expectations with a mindset of conformity to a human being the whole best selves with a mindset of authenticity.

Based on the experience of the author, the following developed innovative tables with different categories of questions have proven to be productive to approach the adequacy of senior leadership. Obviously, these sets of reflective questions are subject to situational and eclectic application by the executive consultant. Also, some of the questions stemming from the developed process of executive consulting (enclosures 1 through 8) and the presented Bloom taxonomy (Bloom, 1956) may be applied. The questions raised, including the order of raising, should always be tailored to the objective of the diagnosis and the specific situation.

Table 3 - the approach of personal leadership of senior leadership

APPROACHING THE PERSONAL LEADERSHIP
How would you reflect on your personal ambitions ?
How would you reflect on your core beliefs ?
How would you reflect on your key values ?
How would you reflect on your leadership authenticity ?
How would you reflect on your transparency practiced ?
How would you reflect on your overall accountability ?
How would you reflect on your success measurements ?
How would you reflect on your commitment building ?
How would you reflect on your power application ?
How would you reflect on your influencing assortment ?
How would you reflect on your resistance mitigation ?
How would you reflect on your bias identification ?
How would you reflect on your hubris countering ?
How would you reflect on your energy balance ?
How would you reflect on your stress tolerance ?
How would you reflect on your feelings adequacy ?
How would you reflect on your delegation effectiveness ?
How would you reflect on your decision making ?
How would you reflect on your priority setting ?
How would you reflect on your time allocation ?
How would you reflect on your restricting emotions ?
How would you reflect on your learning experiences ?

Table 4 - the approach of interactive leadership of senior leadership

APPROACHING THE INTERACTIVE LEADERSHIP
How would you reflect on your leading others ?
How would you reflect on your contextual awareness ?
How would you reflect on your typical roles ?
How would you reflect on your mentoring capabilities ?
How would you reflect on your team development ?
How would you reflect on your fostering collaboration ?
How would you reflect on your opposition institutionalization ?
How would you reflect on your diversity embracing ?
How would you reflect on your status challenging ?
How would you reflect on your expectation management ?
How would you reflect on your feedback provision ?
How would you reflect on your behavioral intolerances ?
How would you reflect on your underperformers' handling ?
How would you reflect on your addressing mediocracy ?
How would you reflect on your confronting difficulties ?
How would you reflect on your disagreement handling ?
How would you reflect on your conflict resolution ?
How would you reflect on your negotiation skills ?
How would you reflect on your overall image ?
How would you reflect on your support system ?
How would you reflect on your trust building ?
How would you reflect on your meeting quality ?

Table 5 - the approach of strategic leadership of senior leadership

APPROACHING THE STRATEGIC LEADERSHIP
How would you reflect on your “swot” analysis ?
How would you reflect on your organizational fitness ?
How would you reflect on your organizational performance ?
How would you reflect on your success definition ?
How would you reflect on your strategic objectives ?
How would you reflect on your strategy execution ?
How would you reflect on your value drivers ?
How would you reflect on your future orientation ?
How would you reflect on your ambition boldness ?
How would you reflect on your disruptive options ?
How would you reflect on your risk appetite ?
How would you reflect on your competitive position ?
How would you reflect on your innovation agenda ?
How would you reflect on your portfolio diversification ?
How would you reflect on your growth opportunities ?
How would you reflect on your strategic alternatives ?
How would you reflect on your opportunities capturing ?
How would you reflect on your threats mitigating ?
How would you reflect on your strengths leveraging ?
How would you reflect on your weaknesses compensating ?
How would you reflect on your crisis preparedness ?
How would you reflect on your change capabilities ?

Table 6 - the approach of resources to build on

APPROACHING THE RESOURCES TO BUILD ON
How would you reflect on your organization's leadership skills ?
How would you reflect on your organization's talent potential ?
How would you reflect on your organization's staff engagement ?
How would you reflect on your organization's brand reputation ?
How would you reflect on your organization's customer base ?
How would you reflect on your organization's market position ?
How would you reflect on your organization's proposition uniqueness ?
How would you reflect on your organization's channel reach ?
How would you reflect on your organization's capital adequacy ?
How would you reflect on your organization's financial vitality ?
How would you reflect on your organization's governance quality ?
How would you reflect on your organization's social embedding ?
How would you reflect on your organization's cultural characteristics ?
How would you reflect on your organization's research capabilities ?
How would you reflect on your organization's systems architecture ?
How would you reflect on your organization's information infrastructure ?
How would you reflect on your organization's technical assets ?
How would you reflect on your organization's supplier relations ?
How would you reflect on your organization's external networks ?
How would you reflect on your organization's guiding policies ?
How would you reflect on your organization's embedded procedures ?
How would you reflect on your organization's sustainable locations ?

In consolidating the diagnosis, the executive consultant should form a fair and unbiased representation about the extent to which senior leadership may be qualified as situationally adequate. This also requires intensively challenging senior leadership, among others through questioning the reasons and substantiations of the provided answers. The following developed table provides guidance for consolidating the observations of senior leadership.

Table 7 - the typical overall observations of senior leadership

MORE PERSONAL OBSERVATIONS	MORE CONTENT OBSERVATIONS
Is active listening demonstrated ?	Is leadership maturity demonstrated ?
Is self awareness demonstrated ?	Is contextual awareness demonstrated ?
Is self reflection demonstrated ?	Is strategic insight demonstrated ?
Is some humility demonstrated ?	Is collegial appreciation demonstrated ?
Is time consistency demonstrated ?	Is status challenging demonstrated ?
Is accountability demonstrated ?	Is disruptive thinking demonstrated ?
Is integrity demonstrated ?	Is boldness demonstrated ?

3.1.2. The diagnostic for approaching adequacy of strategy

In terms of the author, corporate strategy is the way in which the objectives of an organization have to be realized through senior leadership. This notion relates strategy to objectives. Likewise, objectives should fulfill the mission of an organization. This implies that mission, objectives and strategy are associated. Thus, in approaching the situational adequacy of a strategy, also the adequacy of the mission and objectives should be approached.

The different types of strategy are clearly described in the authoritative work of Mintzberg (Mintzberg, Ahlstrand and Lampel, 2009). However, a structured and practice based set of normative standards, serving as a diagnostic, and providing guidance to approach the situational adequacy of the mission, objectives and strategy is currently missing.

In the three following tables, based on the experience of the author, an innovative set of practice based and normative standards, serving as guidelines, has been developed for approaching the adequacy of the mission, objectives and strategy of organizations. These developed diagnostics by the author present state-of-the-art knowledge and demonstrate authority in strategy. This contribution also supports the redefinition of the professional practice of executive consulting.

In the table below, normative standards for approaching the adequacy of missions are presented.

Table 8 - the normative standards for missions

ATTRIBUTES	NORMATIVE STANDARDS FOR MISSIONS
Purpose	The mission explicates the reason for existence clearly
Responsible	The mission clarifies the responsibility to the stakeholders
Identity	The mission captures the core values undoubtedly
Offerings	The mission conceptualizes the proposition plainly
Uniqueness	The mission differentiates sharply from the competitors

Furthermore, an adequate mission has some more procedural characteristics to be taken into consideration, among which credibility, clarity, conciseness, precision, inspiration and simplicity.

In the table below, the developed innovative set of normative standards for approaching the situational adequacy of objectives is presented.

Table 9 - the normative standards for objectives

ATTRIBUTES	NORMATIVE STANDARDS FOR OBJECTIVES
Chances	The objectives credible captures the opportunities from the "swot"
Dangers	The objectives credible mitigates the threats from the "swot"
Vitalities	The objectives credible leverages the strengths from the "swot"
Fragilities	The objectives credible compensates the weaknesses from the "swot"
Options	The objectives consider and reject alternatives deliberately
Anticipatory	The objectives capture innovative breakthroughs
Relevance	The objectives reinforce the fulfillment of the mission
Ambition	The objectives stretch the status quo to a realistic maximum
Specifical	The objectives define clearly what should be accomplished
Outcomes	The objectives describe precisely the required effects
Measurable	The objectives quantify the specific results to be realized
Timeframe	The objectives identify the available time or deadlines
Equitable	The objectives balance the different kinds of goals
Achievable	The objectives provide reasonable assurance for realization
Horizon	The objectives focus on the long term
Priority	The objectives are ranked according to significance
Robust	The objectives can stand the test of time foreseeably
Assigned	The objectives have unambiguous owners

Also based on the experience of the author, the objectives of an organization should typically cover a situational mix of different perspectives to assure sufficient balance. Apart from several other considerations in embedding the objectives, in the informed option of the author, key should always be anchoring the objectives in the appraisals and rewards of staff.

Stemming from the experience of the author, examples of objectives are imago, integrity, satisfaction, values, sustainability, diversity, stakeholders, governance, innovation, growth, markets, segments, distribution, suppliers, customers, products, services, quality, pricing, locations, funding, capital, costs, revenue, margin, profits, leverage, capacity, partnerships, staff, roles, teaming, processes, logistics, competencies, culture, investments, systems, safety, technology, housing and knowledge.

In the table below, the developed innovative set of normative standards for approaching the situational adequacy of strategy is presented.

Table 10 - the normative standards for strategies

ATTRIBUTES	NORMATIVE STANDARDS FOR STRATEGIES
Process	The strategy anchors in a credible "swot" analysis
Alignment	The strategy reinforces the objectives unmistakably
Robustness	The strategy results from different scenarios
Risks	The strategy stems from a thorough risk assessment
Departures	The strategy defines the current states clearly
Destinations	The strategy describes the future states clearly
Roadmap	The strategy explicates the required changes clearly
Means	The strategy allocates all the required resources sufficiently
Effects	The strategy clarifies the consequences of the changes
Mitigations	The strategy minimizes the consequences by measures
Flexibility	The strategy can absorb unexpected events and issues
Ownership	The strategy anchors in clear responsibilities

Regarding strategy, given differences often occurring in product-market combinations, it may be necessary to approach the strategy for product-market combinations separately, for instance in terms of the actual growth and profit as well as their potential. The profit may be determined in terms of the economic value added, thus apart from the direct costs also allocating a fair share of the overhead and capital costs. The specific strategies for product-market combinations may for instance be investments or divestments in integrations (backward or forward), diversifications (in markets and-or products) or internationalizations (also in markets and-or products).

3.2. THE INNOVATIONS FOR MENTAL CONSULTING

3.2.0. The introduction regarding mental consulting

As explained in earlier productions, and in the informed opinion of the author, an etiology credibly explaining the cause of mental disorders, and an overseeable nosology providing a clear classification of mental disorders is missing.

For executive consulting, the rationale for having a credible and thus evidenced etiology is among others to obtain insights about atypical behavioral tendencies and about forms of (milder) mental disorders in relation to senior leadership. This facilitates better diagnoses by focusing on the underlyings of the problems as reported by senior leadership. Also, a credible etiology facilitates the further development of the practice of mental consulting by focusing the diagnosis on a root cause instead of focusing on superficial symptoms of mental disorders.

Likewise, the rationale for having an overseeable nosology is to equip executive consultants with a clear oversight of atypical behavioral tendencies and the symptoms of (mild) mental disorders. Also, an overseeable nosology facilitates the further development of the practice of mental consulting by eliminating the abundant range of classification of mental disorders, foreseeably resulting in better diagnoses and treatments.

Summarizing, one of the more important innovations for both executive and mental consulting is to develop a credible hypothesis for the etiology of atypical behavioral tendencies and mental disorders as well as to develop an overseeable hypothesis for the nosology of mental disorders, bringing the classification of mental disorders back to the essence again.

In the figure below, the position of the etiology and the nosology of mental consulting is visualized in the black ovals, numbered 3 and 4.

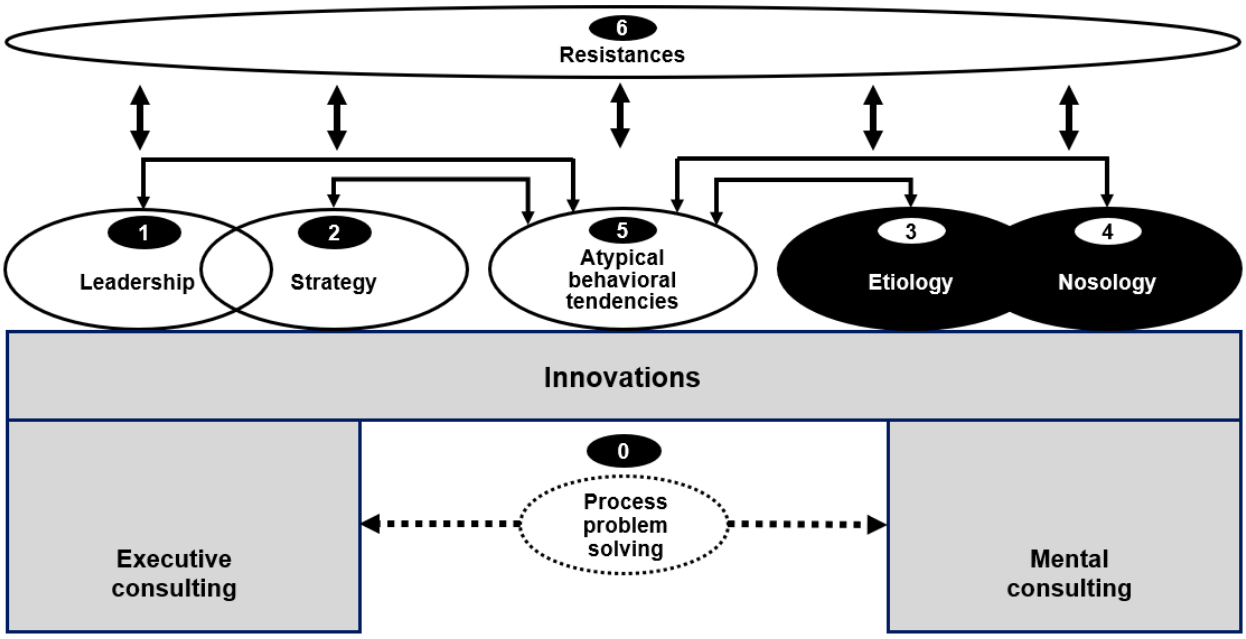

Figure 3 - the innovations in mental consulting

3.2.1. The hypothetical etiology of mental disorders

Loads of research have been conducted on the etiology of mental disorders. Conclusions differ significantly, among others given alternative paradigms and diverse assumptions as well as other statistical methods and different data sets. However, the biopsychosocial model (Engel, 1977) is still considered a leading explanatory model for the etiology of mental disorders.

In short, and in terms of the author, biological factors include genetic vulnerabilities and brain circuitry dysfunctions, psychological factors include egostate tensions and troublesome thoughts, while social factors include adverse relationships and human inequities.

Currently, and heavily promoted by pharmaceutical companies, there is a strong and exclusive tendency towards the biological paradigm. To summarize, this paradigm believes that every mental complaint can be solved with a psychopharmacological drug. In other words, psychiatry has created a diagnosis for almost all of life's misfortunes, also resulting in an overtreatment with drugs (Paris, 2020).

Apart from unrealistic overpromising, in the experience of the author, these agents often do nothing more than temporarily suppressing or softening the superficial symptoms of mental disorders, while the underlying root causes are not eliminated. Also, the risk-benefit ratios of drugs certainly are not undisputed (e.g., Bijl, 2018; Gotzsche, 2013).

Based on the recent insights from epigenetics, and also the experience of the author, the common underlying driving force of the biopsychosocial model, and thus a root cause of mental disorders may hypothetically be the in this respect underestimated phenomenon stress.

The rationale of determining a common underlying root cause of mental disorders is that by eliminating this root cause, their manifestations will inherently be eliminated as well. Thus, while a root cause of many problems in executive consulting often proves to be senior leadership, stress may hypothetically prove to be a root cause in mental consulting. This claim is substantiated as follows.

To start, many alternative definitions for stress are available. The World Health Organization (WHO, 2023) defines stress as “a state of worry or mental tension caused by a difficult situation”. The author appreciates three components in this definition. First, the term “state” explains that stress is a relatively stable condition over time. Second, the term “worry or tension” explains that stress consists of concerns or pressures. Third, the term “difficult situation” emphasizes that stress is caused by a setting that is (perceived to be) difficult to handle or to cope with.

In terms of the author, stress is preceded by stress inducing events, the stressors, each with a certain frequency and intensity. Crucial for experiencing mental problems is to what extent someone has sufficient bearing capacity in relation to the combined and cumulative impact of the stressors. However, everyone is, at least temporarily, shielded by an array of defense mechanisms (Freud, 1936) and other coping mechanisms (DSM, 2002).

Also, in relation to stress and bearing capacity, the extent to which vulnerability from a genetic perspective exists, is important (Stahl, 2021). In cases of sufficient bearing capacity, stress will not express itself immediately in mental disorders.

However, stressors, even including positive experiences, may accumulate over time, reinforced by partly unconscious limbic and cognitive learning processes, up to the point that this accumulation of stressors eventually breaks through someone's bearing capacity, expressing itself in mental disorders or better, a set of mental complaints.

Based on the experience of the author, examples of stressors may be personal factors (for instance illness or discrimination), family factors (for instance quarrels or divorce), work factors (for instance changes and unemployment) and financial factors (for instance debt and poverty). However, stress may also result from the numerous conflicting demands stemming from current society. Examples related to senior leadership are delivering according to the objectives, coping with crises, building a successful career, maintaining good stakeholder relations, facing peer comparisons, handling all kinds of demands, absorbing new technologies, assuring permanent online availability, looking adequately on social media, and being an understanding spouse.

At the same time, stressors trigger the hypothalamic-pituitary-adrenal axis (Kandel et al., 2013). In response to (perceived) stressors as registered by the brain, the hormone cortisol is released as final product of this axis, preparing the body for a stress response. As cortisol levels rise in the bloodstream, under normal conditions, signals are sent back to normalize the cortisol release. However, chronic stress hinders this negative feedback loop. The following prolonged or excessive activation of the axis may lead to changes in the brain, and may subsequently result in the development of mental disorders (Zorn et al., 2017). Also, other research (e.g., Stahl, 2021) evidences that stress may cause neurobiological imbalances in the brain, resulting in dysfunctions in the brain circuitry, and inducing mental disorders.

In terms of the occurrence and effects of stress, a study by the Mental Health Foundation (MHF, 2018) concluded that over the year 2017 almost three quarters of people have at some point felt so stressed that they felt unable to cope. More, the study highlights that of the adults who had felt stress at some point in their lives, 32 percent reported that they had suicidal thoughts and feelings. And these percentages were even before the COVID crisis and are not specifically for senior leadership, often facing much more and intense stressors.

Also, the authoritative Handbook Stress (Cooper and Quick, 2017) explains among others that stress is correlated to seven of the ten leading causes of death in developed nations. Medical research even estimates that as much as 90 percent of illness and disease is stress related (Clemson, 1997).

Furthermore, according to studies of the Centre for Addiction and Mental Health (CAMH, 2021), long term stress induces and increases mental health problems. These problems may influence all three psychological dimensions. First, signs of stress may be cognitive, with manifestations such as concentration difficulties, memory problems, lacking confidence, constant worry and impaired decision making. Second, signs of stress may be emotional, with manifestations such as feeling anxious, feeling depressed, feeling unhappy, feeling agitated and feeling hopeless. Third, signs of stress may be behavioral, with manifestations such as problematic eating and sleeping patterns as well as substance use and neglecting responsibilities.

Likewise, according to the American Psychological Association (APA, 2018), stress has serious effects on all body systems. Stress affects the nervous system, among others triggering and even sustaining fight or flight responses.

Finally, (APA, 2018), stress affects the cardiovascular system, among others increasing blood pressure and inflaming arteries. Also, stress affects the gastrointestinal system, among others weakening the intestinal barrier, triggering all kinds of inflammation as well as changing appetite and digestion. Likewise, stress affects the respiratory system, among others inducing asthma attacks and hyperventilation. Finally, stress affects the musculoskeletal system, among others causing headaches and chronic back pains.

To summarize, authoritative research clearly substantiates the role of stress as a root cause of mental disorders, while the physiological interconnectedness with body systems also makes stress a leading cause of many somatic disorders. Important, regardless of the correlation between mental disorders and stress, the causation is demonstrated. This implies that stress is an effective point of leverage in preventing, early detecting and treating mental disorders, including the atypical behavioral tendencies of senior leadership, which may also be triggered by stress.

Focusing on executive consulting, senior leadership is permanently and heavily exposed to all kinds of stressors, for instance stemming from executing the strategy and delivering accordingly, while having to cope with all kinds of far reaching developments and conflicting demands stemming from many different stakeholders. Thus, it should not be surprising that senior leadership may develop atypical behavioral tendencies and even (mild) mental disorders, caused by stress, damaging the organization.

The presented research about stress is in line with the experience of the author, in terms of stress being a root cause of both atypical behavioral tendencies and mental disorders. The following developed model by the author presents the innovative hypothesis for the etiology.

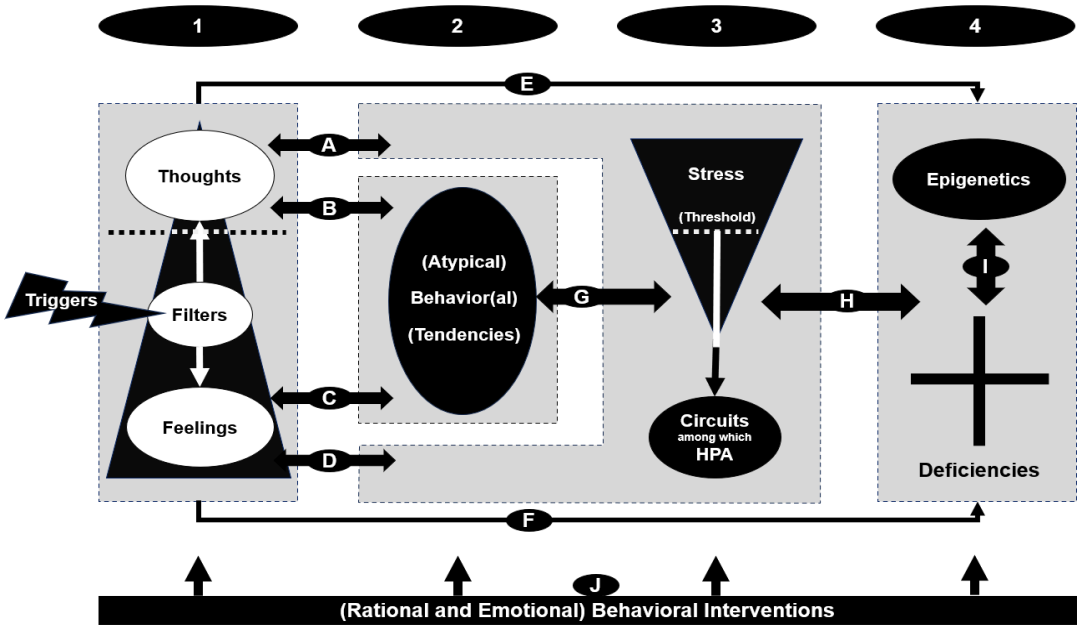

Figure 4 - the etiology of mental deficiencies

Triggers from the environment pass all kinds of distorting filters, before these triggers cause all kinds of thoughts and feelings (oval 1). These thoughts (arrow B) and feelings (arrow C) result in behavior, sometimes in the form of atypical behavioral tendencies (oval 2). If thoughts (arrow A) or feelings (arrow D) are experienced as stressful crossing the bearing threshold, stress will occur, resulting in dysfunctional circuits in the brain (oval 3). Also, atypical behavioral tendencies (oval 2), may cause stress and dysfunctional brain circuitry and vice versa (arrow G).

The thoughts or feelings (oval 1) may even be so intense or frequent, that they immediately cause epigenetics (arrow E) or deficiencies in the form of mental disorders (arrow F). Also, the stress and dysfunctional brain circuitry may result in epigenetics and deficiencies in the form of mental disorders and vice versa (arrow H). Epigenetics (e.g., Paro et al., 2021) change the expression of genes and thus the creation of proteins, which may cause mental disorders.

Finally, behavioral interventions (arrow J) may eliminate disturbing thoughts or feelings (arrow J to oval 1) and atypical behavioral tendencies (arrow J to oval 2) as well as may eliminate stress (arrow J to oval 3) and reverse epigenetics plus deficiencies in the form of mental disorders (arrow J to oval 4).

3.2.2. The hypothetical nosology for mental consulting

First of all, the reported lifetime prevalence of any mental disorder is nearly 50 percent (Asadi, Klein and Meyer, 2015). In the opinion of the author, this number may be significantly higher in the more stressful environments of senior leadership. Also, real percentages will be higher, given that the abnormal may be masked in highly competent ways (Cleckley, 1955), given that no one from the outside is able to look inside, and can experience what a person really feels or thinks.

This once more emphasizes the relevance of having psychological diagnostic skills in executive consulting. The role of executive consultants in this respect should not be a box ticking or disorder labeling exercise. Besides, the worldwide costs of mental disorders are expected to rise to an astonishing USD 6 trillion in 2030 (Dutch Government, 2024), apart from all indirect and social costs, which have to be borne directly and indirectly by senior leadership.

The current nosology of mental disorders as codified in the DSM (DSM, 2022) faces many shortcomings, hindering the diagnosis and treatment of mental disorders, while also complicating the valuable transfer of insights about atypical behavioral tendencies and mental disorders to executive consulting. First, the number of mental disorders distinguished has accelerated energetically from a handful (Kraepelin, 1899) to an astonishing 541 (Blashfield et. al., 2014).

Also, the DSM (DSM, 2013) faces up to 90 percent overlap in the distinguished mental disorders (Möller et al., 2016). Likewise, the DSM (DSM, 2013) faces comorbidities of up to 80 percent (Spoorthy, Chakrabarti and Grover, 2019).

Given this manufactured complexity as well as overlaps and comorbidities, it may not be surprising that misdiagnosis rates of mental disorders in primary care are over 90 percent (Vermani, Marcus and Kathmandu, 2011), while the interrater kappa-scores of the two most frequently occurring mental disorders are a disappointing 0.2 for anxiety disorders and 0.28 for depressive disorders (Regier et al., 2013). Moreover, when the DSM-IV (DSM, 2002) was still in use, and the rest classification “not otherwise specified” still existed, this classification used to be the most common diagnosis with 49.5 percent (Rajakannan et al., 2016).

At the same time, personality disorders were and still are strictly separated from mental disorders, also complicating diagnoses. In the DSM-IV (DSM, 2002), even a separate axis was introduced for personality disorders, which was removed in the succeeding DSM (DSM, 2013).

However, it was concluded from many different perspectives that it is impossible to conclude with confidence that personality disorders are or are not mental illnesses (Kendell, 2002). Also, it was concluded (Widiger, 2011) that personality disorders and psychopathologies exist along a common spectrum. Furthermore, other research (e.g., Hayward and Moran, 2008) evidences the associations between personality and mental disorders. Likewise, it has been argued that personality disorders may represent a noteworthy and relevant vulnerability marker or risk factor for mental disorders (Boldrini et al., 2019).

Based on the experience of the author, the current DSM (DSM, 2022) also faces several other issues in the diagnosis of mental disorders. For instance, this DSM implicitly codifies abnormality by setting criteria, giving rise to the risk of the medicalization of nothing more than distributions of what still may be considered as normal behavior. Also, this DSM labels mental disorders with abundant ranges of symptoms, giving rise to the risk of self-fulfilling prophecies, if someone identifies with that full set of symptoms.

Furthermore, box-ticking exercises regarding arrays of criteria and rigidly applied questionnaires may shift attention from someone to something, with the risk of replacing person focused attention for paper. Moreover, many symptoms are multi interpretable and more or less synonymous. This implies that the demarcation of each diagnostic compartment is far from unambiguous. Thus, while already difficult to distinguish diagnostic compartments in theory, this will even be much more difficult in practice.

Summarizing, the cumulation of these shortcomings is not very promising for adequate diagnoses of mental disorders. As mentioned earlier, if the diagnosis is inaccurate, everything that follows, among which the treatments, will foreseeable be inaccurate as well. Besides, these shortcomings and the manufactured complexity in mental consulting also hinders the transfer of insights to executive consulting, while insight in (the classification of) foremost the milder forms of mental disorders is important for executive consulting as argued earlier.

As mentioned, the theoretical model as codified in DSM (DSM, 2022), assumes that the diagnosis of mental disorders is to a high extent discretionary, and thus can be placed into well demarcated diagnostic compartments.

These compartments of DSM (DSM, 2022) are without many overlaps, while the personality disorders form a separate category. This is visualized in the following figure by the author.

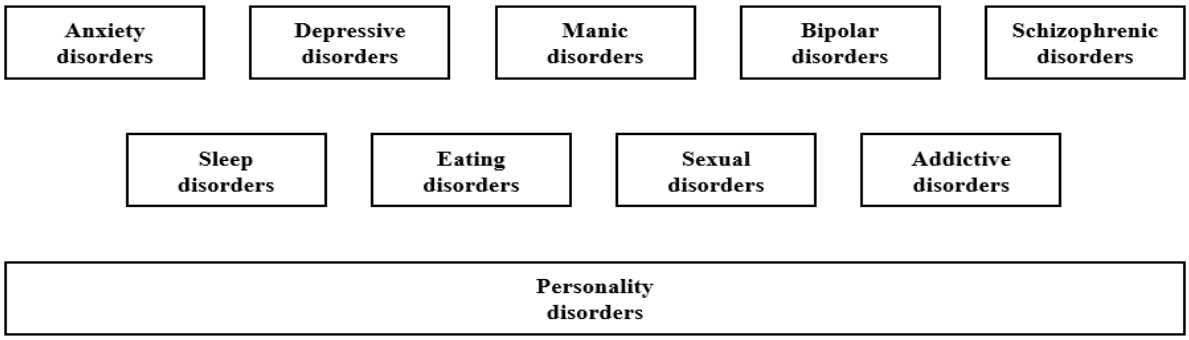

Figure 5 - the theoretical current nosology of mental disorders

However, as explained, reality is that mental disorders face rich overlaps in symptoms and many comorbidities, visualized by the overlapping boxes and relationship lines in the figure below.

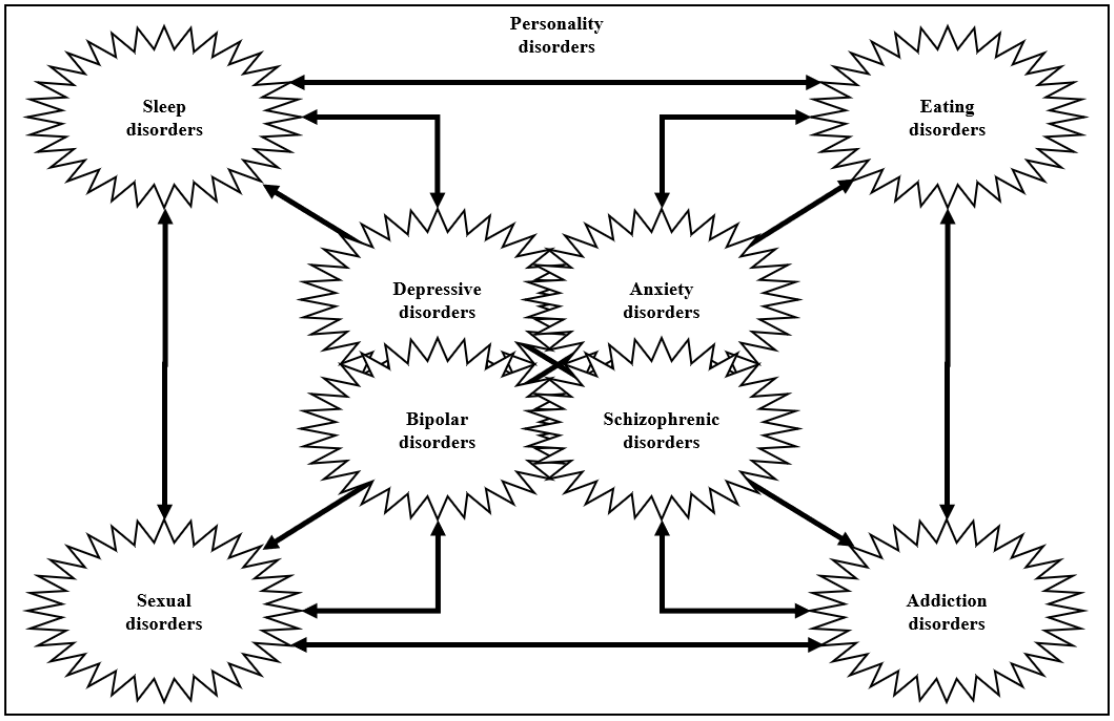

Figure 6 - the practical current nosology of mental disorders

To mitigate these shortcomings, the author developed a disruptive and thought-provoking hypothetical nosology by changing the current rather arbitrary compartmentalizations of mental disorders into two axes, forming four continua of archetypical mental complaints. All mental disorders can be projected on this combination of continua. The innovative nosology is built on research (Gu et al., 2019; Jack, Garrod and Schyns, 2014), while also including the theory of primary emotions (Plutchik, 1962) and the theory of emotions (Frijda, 1988). However, these studies are focused on and limited to emotions, while the author strongly believes that emotions form a spectrum with mental disorders.

Apart from the ancient Greeks, also other two axis models stemming from research relate to the thought-provoking nosology by the author (e.g., Eysenck, 2014; Jung, 1968; Marston, 2019), however, with different background and continua.

The developed nosology does justice to the principle of parsimony. The disruptive framework for redefining the professional practice of mental consulting has two dimensions, combined giving rise to four archetypes. The first dimension is sadness versus happiness as the most elementary mood expressions, giving rise to the deflated versus inflated states. The second dimension is fear (flight) versus anger (fight) as the most elementary stress reactions, giving rise to the imploded versus exploded states.

In terms of the author, the deflated states are comparable to depressive disorders and the inflated states to manic disorders, while the imploded states are comparable to anxiety disorders and the exploded states to disruptive disorders. This is visualized in the following thought-provoking and hypothetical model by the author.

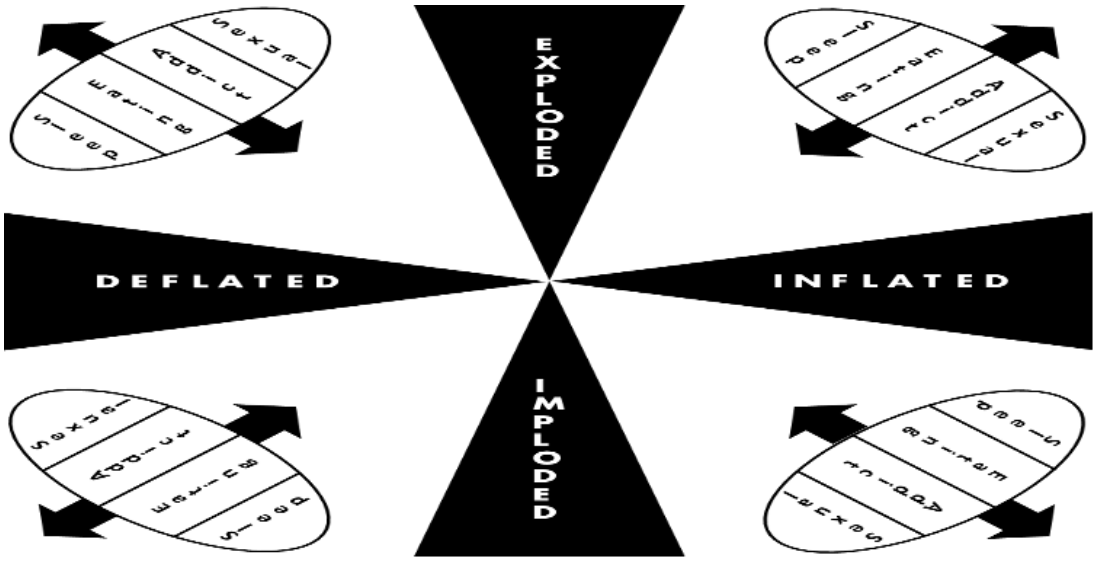

Figure 7 - the proposed nosology for mental disorders

Regarding two other common mental disorders, bipolarity is a cycling state, characterized by switching between deflated and inflated states, while schizophrenia is a coexisting state, characterized by concurrence of both deflated and inflated states.

Each of the four developed archetypes consists of a continuum of mental complaints instead of quasi fixed compartments of mental disorders. These continua form ranges of intensity or severity of mental complaints as expressed by someone. In relation to mental consulting, the four archetypes are sufficient for both diagnosis and treatment, as substantiated hereafter.

The continua of mental complaints are composed of (i) the attributes stemming from a certain character structure, (ii) the issues stemming from typical thinking deficiencies, (iii) the exaggeration of emotions, (iv) the problems stemming from atypical behavioral tendencies, (v) the symptoms stemming from personality disorders and (vi) the spectrum of symptoms caused by mental disorders.

In the conviction of the author, there is no practical need for decomposing any further than the four archetypes. This is because the psychotherapeutic treatment in the form of cognitive behavioral therapy has been found to be highly omnipotent (e.g., Butler et al., 2006; Hofmann et al., 2012), usually serving all four archetypes.

Likewise, the psychopharmacological treatment of the four archetypes is covered by two broad classes of drugs (Stahl 2021). Antidepressants are used against deflated and imploded states. Antipsychotics are used against inflated and exploded states as well as against severely deflated and severely imploded states. Also, antipsychotics are used in cycling and coexisting states, while stabilizers may also be used against cycling states. Thus, there is no practical or clinical value in having all kinds of fine mazed quasi diagnostic compartments if the psychotherapeutic and psychopharmacological treatment of all of the manufactured compartments is not different.

Also, it remains difficult to falsify to what extent mental disorders disappear simply because of time or attention, even if no drugs were given. At the same time, psychopharmacology seldom solves the underlying causes, but often only suppresses or softens superficial symptoms. Finally, statistical significance in the efficacy of drugs may differ from clinical significance.

For each of the four archetypes, the author has developed innovative supersets of mental complaints. The sequence in terms of intensity or severity within these supersets of mental complaints is still tentative. However, the supersets of mental complaints provide guidance for estimating the relative position on the continuum in terms of the severity of the mental complaints, and for potentially subsequent complaints, including the need for direct intervening.

Related to the developed nosology, are sleeping and eating complaints as well as addictive and sexual complaints. Hypothetically, these complaints may be both triggers and consequences of the four archetypal states, but they may also be independent from the archetypes. This is visualized by the position of the ovals in the proposed model.

As argued, in the informed opinion of the author, the developed nosology may have stress as a root cause underlying each of the four archetypes. Apart from the earlier provided arguments, an additional argument is that if and when stress occurs, the basic assortment of reactions is ‘flight’ (comparable with imploded states) or ‘fight’ (comparable with exploded states). Depending on the way in which the effects following the stress reaction are appreciated, different intensities of dissatisfaction (comparable to deflated states) or different intensities of satisfaction (comparable with inflated states) result. A related overall perspective is that mental disorders will occur if an organism cannot overcome stressful events (Wang et al., 2018).

Furthermore, a more strict demarcation may be necessary between mental disorders and mental illnesses, the latter including developmental and neurodegenerative as well as trauma issues. These mental illnesses are outside the scope of this contribution.

Also, in innovating nosology, a shift is made from mental disorders to mental complaints as the elementary entities for diagnosis and treatment. By focusing on the mental complaint that is experienced as the most hindering, the consultant explicitly acknowledges the subjective hinder as expressed by someone. Furthermore, given the broad coverage of both psychotherapeutic and psychopharmacological treatments as explained, comorbid less hindering mental complaints than the expressed most hindering, will often inherently be treated as well.

The following table presents the archetype deflated states, forming a continuum of mental complaints.

Table 11 - the examples of the deflated states

The examples of the deflated states
Introspective, introvert, pessimistic, skeptical, negative, passive, inactive, disinterest, hesitant, indecisive, shallow, indifference, inertia, reserved, retardant, unfocused, inferior, worthless, selfblame, purposeless, detached, isolated, distant, sad, tearful, melancholic, numb, flat, anhedonia, avolition, disillusioned, mournful, fatalistic, apathetic, anergia, miserable, helpless, defeated, emptiness, exhausted, drained, hopeless, desperate, broken, crushed, suicidal.

The following table presents the archetype inflated states, forming a continuum of mental complaints.

Table 12 - the examples of the inflated states

The examples of the inflated states
Extravert, optimistic, positive, hopeful, lively, flamboyant, alert, energized, content, happy, cheerful, passionate, eager, euphoric, thrilled, delighted, ecstatic, jubilant, talkative, rattling, impatient, fidgeting, jumpy, courageous, fearless, rebellious, exited, aroused, restless, elevated, distracted, expansive, ideaflight, irritable, unpredictable, uncontrollable, indiscrete, irresponsible, disorganized, directionless, chaotic, grandiosity, theatrical, dramatic, confused, delirious, derealization, eccentricity, weirdness, illusional, magical, delusional, hallucinational.

The following table presents the archetype imploded states, forming a continuum of mental complaints.

Table 13 - the examples of the imploded states

The examples of the imploded states
Defensive, discomfort, nervous, tensed, vulnerable, fragile, alert, vigilant, restless, guarded, alarmed, upset, rigid, obsessive, compulsive, distrustful, insecure, avoidance, clingy, worried, concerned, troubled, anxious, scared, fearful, frightened, withdrawal, disengagement, derailment, dissociative, intrusiveness, overwhelmed, wounded, horrified, devastated, tortured, nightmarish, panic, paralyzed, shutdown.

The following table presents the archetype exploded states, forming a continuum of mental complaints.

Table 14 - the examples of the exploded states

The examples of the exploded states
Tempered, annoyed, bothered, cynical, sarcastic, stubborn, argumentative, critical, judgmental, disagreeable, contradictory, irritated, agitated, confrontational, obstinate, provocative, disregarding, deceitful, scrupulous, humiliating, frustrating, embittered, revengeful, vindictive, criticizing, accusing, blaming, insulting, offensive, asocial, aggressive, combative, boiling, intimidating, threatening, bullying, damaging, hostile, hateful, obnoxious, furious, outraged, shocking, exploded, attacking, fighting, selfharm, injuring, manslaughter.

Like any model, the developed nosology also has disadvantages, for instance affecting a long lasting tradition around the taxonomy of mental disorders. Paraphrasing Machiavelli (2011), there is nothing more difficult to take in hand than the introduction of a new order of things. This implies that new ideas often cause at least substantial criticism, given that everyone is keen on maintaining cognitive and emotional homeostasis, apart from commercial interests.

Obviously, a nosology is nothing more or less than a model, implying that it is an imperfect representation of reality. Also, in the proposed nosology, the developmental disorders (for instance ADHD and autism) and the deterioration neurodegenerative disorders (for instance dementias) as well as disorders stemming from traumas (for instance accidents and strokes) are left out of scope. This is because the author strongly believes that these are not mental disorders but more brain related phenomena. Finally, over the literally millions of studies around mental disorders, much heterogeneity in perspectives and opinions occur, among others caused by alternative paradigms and diverse assumptions as well as other methods and different datasets.

Finally, according to the author, and based on the earlier provided insights, the diagnosis and treatment process of mental complaints may be structured as follows.

Table 15 - the diagnosis and treatment process

The diagnosis and treatment process of mental disorders
Intaking the person in accordance with the current best practices
Identifying the most hindering mental complaints as expressed by a person
Assuring that the underlying cause is not a (symptom of) somatic illness
Keeping the expressed mental complaint(s) and the person central
Determining to what extent there may be danger for the person or others
Considering possible cycling or coexisting states and other interrelations
Selecting the best possible proven treatment, which also may be given time or attention
Monitoring in terms of recovery as well as side-effects and remaining complaints
Solving possible remaining side-effects and complaints
Focusing on the prevention of relapses or reoccurrences of mental complaints

3.3. THE INNOVATIONS COMBINED FOR CONSULTING

3.3.0. The introduction regarding combined consulting

Related to both executive and mental consulting are the atypical behavioral tendencies and the resistances, which are visualized in the following figure, numbered 5 and 6.

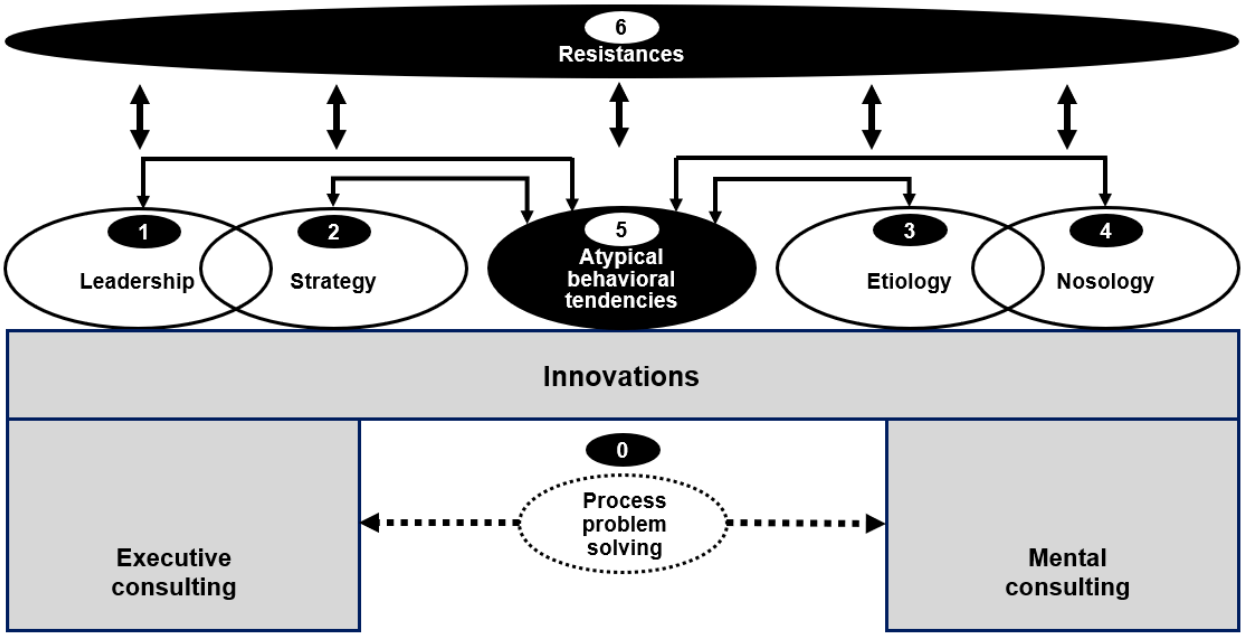

Figure 8 - the combined innovations

3.3.1. The diagnostic for approaching atypical behavioral tendencies

As already argued, the relevance of a diagnostic for approaching the atypical behavioral tendencies in relation to senior leadership is immense.

This is because senior leadership may practice a leadership style that suits their atypical behavioral tendencies instead of practicing a leadership style that is required. Following this, senior leadership may formulate and execute a strategy that serves their atypical behavioral tendencies instead of formulating and executing a strategy that is required. These atypical behavioral tendencies of senior leadership may among others result in counterproductive strategies, counterproductive teams, counterproductive cultures, and eventually even in severe continuity problems of organizations. From that perspective, it is crucial to have a practice based diagnostic for approaching the potential for atypical behavioral tendencies of senior leadership.

Based on the experience of the author, also in relation to mental consulting, in the table below an innovative diagnostic for approaching the atypical behavioral tendencies of senior leadership is developed and presented. However, it should be noted that the indicators are stereotypical representations. This also implies that all indicators should be approached in context and in relation to each other in order to approach the potential for atypical behavioral tendencies in relation to senior leadership. In approaching atypical behavioral tendencies, multidisciplinary skill sets and rich experience are required, given that the diagnosis is far from a checklist exercise. The implications for integrity were already presented.

One of the authors initiating research about the relationships between organizations and so called neurotic leaders is Kets de Vries (Kets de Vries and Miller, 1984). However, these phenomena are not anchored in a coherent diagnostic as is the case with the developed and innovative diagnostic by the author.

Table 16 - the diagnostic for approaching atypical behavior tendencies

INDICATOR	GRANDIOSE	FEARFUL	SOMBER
Source	Case 1	Case 2	Case 3
Cluster	Mostly B related	Mostly C related	Mostly A related
Psychiatric	Mania	Anxiety	Depression
Metaphor	Roller coaster	Tightrope walk	Dark clouds
Reframed	Entrepreneurial	Cautious	Stable
Orientation	Future	Present	Past
Strategy	Inconsistent	Vague	Reactive
Leadership	Charismatic	Micromanager	Isolated
Governance	Adhocracy	Bureaucracy	Archipel
Culture	Stressful	Tensed	Fatalistic
Staff	Confused	Insecure	Passive
Deciding	Impulsive	Postponing	Avoiding
Risks	Excessive	Minimizing	Indifferent
Energy	Limitless	Vigilant	Inactive
Contact	Impatient	Restricted	Withdrawn

Apart from these three case-derived atypical behavioral tendencies, also the aggressive atypical behavioral tendency was sparsely observed, completing the innovative diagnostic. Based on the experience of the author, these aggressive atypical behavioral tendencies result in fear and tension in an organization, while also being highly destructive for teams and culture as well as for an adequate strategy realization.

3.3.2. The diagnostic for approaching foreseeable resistances

In earlier modules, the occurrences of resistance have already been presented. However, one of the major shortcomings is the lack of a practice based diagnostic for approaching the foreseeable resistance in the diagnosing process. In this paragraph, an innovative diagnostic is developed and presented for approaching the foreseeable resistance in diagnosing.

The role of resistance is crucial in both executive and mental consulting. Among others, resistance may damage organizations, caused by uncertainty, fear, worry or even sabotage.

Conceptually and based on the experience of the author, resistances have three main causes. The first is cognitive in terms of not understanding the reasons for diagnosis. The second is rational in terms of disliking or anticipating the interventions, potentially following the diagnosis. The third is emotional in terms of antipathy towards the consultant. Interesting is that these causes are often based on untested assumptions, thus on biases.

Based on in earlier sections presented ideas about the occurrences of resistances, the following questions may approach the foreseeable resistance in diagnosing and in the succeeding changes. The more the answers on the indicators tend towards the right (“most positive”), the less resistance is foreseeable and the other way around.

Based on the combination of all indicators regarding resistance, the executive consultant can determine for instance the roles to take, the interventions to apply and the authorities to exercise in relation to the diagnosis and later in relation to the changes. These roles, interventions and authorities have also already been presented in earlier modules.

Table 17 - the diagnostic for approaching potential resistances

MOST NEGATIVE	INDICATOR	MOST POSITIVE
Threatening	*Vision*	Inspiring
Vague	*Objectives*	Understandable
Mutated	*Leadership*	Reinforced
Many	*Consequences*	Few
Incongruent	*Culture*	Congruent
Changing	*Responsibilities*	Same
Absent	*Competences*	Present
Affected	*Employment*	Unaffected
Unsure	*Guarantees*	Sure
Weak	*Sponsorship*	Strong
Restricted	*Resources*	Available
Insufficient	*Time*	Sufficient
Unknown	*Risks*	Overseeable
Extensive	*Scope*	Limited
Poor	*Communication*	Adequate

3.4. THE INNOVATIONS FROM ARTIFICIAL INTELLIGENCE

3.4.0. The introduction regarding artificial intelligence

The role of artificial intelligence is very promising, and will foreseeably transform practices as well as organizations and even entire ecosystems fundamentally.

McKinsey provides a state-of-the-art overview of the potential of artificial intelligence in the form of bundling 100 relevant articles (McKinsey, 2024c).

In terms of the author, traditional automation requires relatively long development processes for programs, however, currently also supported by artificial intelligence. The algorithms embedded in programs are rigid and receive data as input, while providing information as output. Artificial intelligence in the form of deep machine learning is able to learn from data, while also being able to suggest or even make decisions.

In the application of artificial intelligence, some forms of assurance are indispensable (based on Thakkar, Gupta and De Sousa, 2024), among which the following. To start, it is of the utmost importance to assure human oversight for including non machinery checks and accountability. Also, it is crucial to train the artificial intelligence algorithms with diverse data sets in order to prevent biases as much as possible. Likewise, it is important to anonymize sensitive data to protect privacy and confidentiality. Finally, it is relevant to get explanations to obtain transparency about the reasons behind the provided results. Of course, also auditing artificial intelligence is key in order to test for biases, vulnerabilities and ethics.

In executive consulting, the role of artificial intelligence will foreseeably be limited because of the indispensability of personal interactions. However, in mental consulting, the role of artificial intelligence may be massive, among others given that much of the diagnosis is highly algorithm based, while treatment is also highly standardized (Stahl, 2024).

3.4.1. The artificial intelligence in executive consulting

As explained in earlier modules, executive consulting differs significantly from management consulting. The nature of executive consulting is characterized by intensive one-on-one and oral interactions, exclusively with senior leadership with real time interventions. This also makes that the current and potential role of artificial intelligence is less prominent in executive consulting as compared to management consulting. The current and foreseeable application of artificial intelligence in management consulting is researched by for instance the Management Consulting Journal (Oarue-Itseuwa, 2024) and the International Council of Management Consulting Institutes (ICMCI, 2024).

However, even in executive consulting, artificial intelligence may be supportive in developing a corporate strategy, for instance in performing advanced market analyses, including product-market segmentations and performing various benchmarking exercises.

From another perspective, artificial intelligence narrowly relates to executive consulting. An executive consultant should be able to advise and challenge senior leadership about the potential of artificial intelligence in their organization as a supportive tool and foremost as a competitive edge.

Many insights about and approaches for artificial intelligence are available and are referred to in order to prevent redundancies (e.g., Deloitte, 2024; McKinsey, 2024d; PWC, 2024). Regarding artificial intelligence, executive consultants have to be fully aware of the potential of artificial intelligence for the strategy of an organization.

3.4.2. The artificial intelligence in mental consulting

The foreseeable role of artificial intelligence in mental consulting is massive and will foreseeably progress at a high pace, reshaping the profession and offering unprecedented possibilities, also in combination with big data.

Artificial intelligence is also able to acquire and uniform as well as to process and interpret big data. According to the author, the value for mental consulting is among others performing advanced statistics to improve interventions, renewing the classification of mental disorders, engineering new treatments for mental disorders and detecting potential biomarkers for mental disorders. Following this, artificial intelligence may also be helpful in the education and training of mental consultants.

Examples of functions artificial intelligence can perform in mental consulting are summarized in the following table. This table is inspired by and based on recent research (Sun et al., 2023; Thakkar, Gupta and De Sousa, 2024).

(this part is intentionally left blank)

Table 18 - the application of artificial intelligence in mental consulting

The application of artificial intelligence in mental consulting
Predicting the risk of developing certain mental disorders
Identifying the prodromal stages of mental disorders
Giving early warnings for the occurrence of mental disorders
Identifying the more severe risks among which suicide risks
Assisting in the diagnosis of mental disorders
Determining the treatment options for mental disorders
Making prognoses about the development of mental disorders
Offering insights in potential triggers of mental disorders
Recommending tailored interventions based on individual characteristics
Tracking progress of the results of the interventions
Monitoring the side-effects of medication and other treatments
Improving the adherence of taking medication
Enhancing the awareness of mental disorders through psycho-education
Helping with informed decisions about the self-regulating of mental disorders
Providing virtual reality and other online assistance and interventions
Integrating advice and support in mobile self-help applications
Facilitating convenient e-consults with consultants
Generating accumulated insights derived from aggregated data

Also, the current state of artificial intelligence already has a level of sophistication, making it possible to analyze emotional states of someone.

This can be realized through a spectrum of data, related to words, images, facial expressions, gaze directions, gestures, voices, and physiological signals, for instance heart rate, body temperature, respiration frequency and skin connectivity.

Also, the use of virtual and augmented reality is promising as a psycho-educational and therapeutic tool (e.g., Lan et al., 2023; Tay, Xie and Sim, 2023).

At the same time, the author holds the strong opinion that mental consulting can not be replaced by artificial intelligence either. Artificial intelligence will assist and support mental consultants in diagnosing and treating mental disorders. Furthermore, human oversight should always be in place in relation to the suggested recommendations, while this oversight should also include being aware of overdiagnosis of still normal mental conditions. Also, the function of personal interaction and empathy should not be underestimated.

Finally, as explained in earlier modules, the introduction of new technology should be embedded holistically, thus among others anchored in the competences and the culture as well as in the ways of appraising and rewarding.

P.S. The considerations about implementing the presented innovations have not been overlooked. Because the author will use the innovations exclusively for his own practice, implementing is effortless, and no special activities are required, given that all required expertise, skills and experience are available. Also, other considerations about implementing have already been explained in earlier modules.

ENCLOSURES

Enclosure 1 - the initial diagnosis in problem solving

In the table below, an innovative subprocess is presented, including the typical but situational activities of the initial diagnosis in the problem solving of executive consulting. This subprocess is based on the experience of the author in both executive and mental consulting. The objective of this diagnosis is obtaining basic situational awareness. Output is an early appreciation of the experienced problems, subject to progressive insights.

Table 1 of enclosure 1 - subprocess initial diagnosis in problem solving (updated)

The activities of the subprocess "initial diagnosis" in problem solving
What are the reasons to involve an executive consultant ?
What are the problems as experienced ?
What is the determining coalition in the problems definition ?
What is the nature of the problems ?
What is the course of the problems ?
What is the duration of the problems ?
What are the consequences or symptoms of the problems ?
What is the importance in solving the problems ?
What is the urgency in solving the problems ?
What are given boundary conditions in problem solving ?
What are other limitations in problem solving ?
What is the initial scope in problem solving ?
What are the most involved stakes in problem solving ?
What are the desired or required results of problem solving ?

Enclosure 2 - the retrospective diagnosis in problem solving

In the table below, an innovative subprocess is presented, including the typical but situational activities of the retrospective diagnosis in problem solving. The concept of retrospective diagnosis is derived from mental consulting, and based on the experience of the author, tailored for executive consulting. This also implies that an explicit retrospective diagnosis is entirely new to executive consulting. The objective of this diagnosis is approaching the experience of the organization and of senior leadership with problem solving. Output is an overview of the handling of earlier problems, including the accumulated learning experiences.

Table 2 of enclosure 2 - subprocess retrospective diagnosis in problem solving (updated)

The activities of the subprocess "retrospective diagnosis" in problem solving
What were the earlier experienced problems ?
What were the essences of the earlier experienced problems ?
What were the experienced consequences or symptoms of the problems ?
What were the alternatives considered in problem solving ?
What were the initiatives undertaken in problem solving ?
What were the interventions applied in problem solving ?
What were the results or effects of the initiatives in problem solving ?
What were the windfalls of the earlier initiatives in problem solving ?
What were the setbacks of the earlier initiatives in problem solving ?
What were the learning experiences from the earlier initiatives ?
What are the differences with the earlier problems ?

Enclosure 3 - the sponsor diagnosis in problem solving

In the table below, an innovative subprocess is presented, including the typical but situational activities of the sponsor diagnosis in the problem solving of executive consulting. This subprocess is based on the experience of the author in both executive and mental consulting. The objective of this diagnosis is approaching some characteristics of senior leadership in their role as sponsor. Output is an initial appreciation of the sponsor. Among others, these observations will be used to determine the approach, the interventions and the forms of authority to apply.

Table 3 of enclosure 3 - subprocess sponsor diagnosis in problem solving (updated)

The activities of the subprocess "sponsor diagnosis" in problem solving
What are the personal motives for problem solving ?
What are the most important personal priorities ?
What are the biggest personal challenges ?
What are the biggest personal concerns ?
What are the biggest personal dilemmas ?
What are the recurring personal issues ?
What are the issues requiring the most personal time ?
What are the issues requiring the most personal energy ?
What are the personal circles of influence ?
What are the personal investments willing to make ?
What are the personal measures of success ?

Enclosure 4 - the problem diagnosis in problem solving

In the table below, an innovative subprocess is presented, including the typical but situational activities of the problem diagnosis in problem solving. This subprocess is based on the experience of the author in both executive and mental consulting. The objective of this diagnosis is determining the problems as experienced by senior leadership. Output is a set of initial hypotheses about the reported problems, including some relevant characteristics of the problems.

Table 4 of enclosure 4 - subprocess problem diagnosis in problem solving (updated)

The activities of the subprocess "problem diagnosis" in problem solving
What is the core of the problems ?
What is the problem in one sentence ?
What are the consequences or symptoms of the problems ?
What are the trigger events of the problems ?
What is the relevant context of the problems ?
What is the impact of the context of the problems ?
What are the different stakeholders around the problem ?
What are the problems the different stakeholders experience ?
What are the interests of the different stakeholders in problem solving ?
What is the prognosis if the problems remain the same ?
What are the different perspectives on the problems ?
What are the goals to be accomplished in problem solving ?
What is required for accomplishing the goals in problem solving ?
What are the anticipated obstacles in accomplishing the goals ?

Enclosure 5 - the underlying diagnosis in problem solving

In the table below, an innovative subprocess is presented, including the typical but situational activities of the underlying diagnosis in the problem solving of executive consulting. This subprocess is based on the experience of the author in both executive and mental consulting. The objective of this diagnosis is determining the deeper lying causes as well as the maintaining processes behind the reported problems. Output is a set of revised hypotheses about the root causes of the problems.

Table 5 of enclosure 5 - subprocess underlying diagnosis in problem solving (updated)

The activities of the subprocess "underlying diagnosis" in problem solving
What are the research questions for this subprocess ?
What is the demarcation or scope in problem solving ?
What are the repeating patterns surrounding the problems ?
What are the untested or implicit assumptions around the problems ?
What are the underlying causes of the problems ?
What are the interrelations over the underlying causes ?
What is preventing the elimination of the underlying causes ?
What are the maintaining processes behind the underlying causes ?
What are the mechanisms behind the maintaining processes ?
What are the interrelations over the maintaining processes ?
What is preventing the elimination of the maintaining processes ?
What are the potential hidden motives around problem solving ?
What are the options or the needs for innovations in problem solving ?

Enclosure 6 - the effort diagnosis in problem solving

In the table below, an innovative subprocess is presented, including the typical but situational activities of the effort diagnosis in the problem solving of executive consulting. This subprocess is based on the experience of the author in both executive and mental consulting. The objective of this diagnosis is approaching the resistances in problem solving. Output is the foreseeable efforts required in problem solving, including the roles to take and the interventions to apply.

Table 6 of enclosure 6 - subprocess effort diagnosis in problem solving (updated)

The activities of the subprocess "effort diagnosis" in problem solving
What is the reach of the problems to be solved ?
What are the compulsory projects in progress or in portfolio ?
What are the foreseeable positive effects for each stakeholder group in problem solving ?
What are the foreseeable negative effects for each stakeholder group in problem solving ?
What are the experienced forms of defenses ?
What are the potential forms of defenses ?
What are the experienced forms of resistances ?
What are the potential forms of resistances ?
What are the financials required in problem solving ?
What are the resources required in problem solving ?
What is the time required in problem solving ?
What is the extent to which the required resources are available ?
What are the biggest potential obstacles in problem solving ?
What are the acceptable concessions in problem solving ?

Enclosure 7 - the differential diagnosis in problem solving

In the table below, an innovative subprocess is presented, including the typical but situational activities of the differential diagnosis in the problem solving of executive consulting. The concept of differential diagnosis is derived from mental consulting, and based on the experience of the author, tailored for executive consulting. This also implies that an explicit differential diagnosis is entirely new to executive consulting. The objective of this diagnosis is discriminating between different diagnostic options. Output is obtaining reasonable certainty about the diagnosis of the problems.

Table 7 of enclosure 7 - subprocess differential diagnosis in problem solving (updated)

The activities of the subprocess "differential diagnosis" in problem solving
What are the core problems (potentially) related to leadership ?
What are the core problems (potentially) related to strategy ?
What are the core problems (potentially) related to governance ?
What are the core problems (potentially) related to culture ?
What are the combined results stemming from the diagnosis ?
What are the potential alternative diagnoses stemming from the diagnosis ?
What are the falsifications of the alternative diagnoses ?
What are the pros of each of the alternative diagnoses ?
What are the cons of each of the alternative diagnoses ?
What are the additional diagnostic insights from the professional experience ?
What are the potential diagnostic distortions stemming from biases ?
What are still open considerations or issues in relation to the diagnosis ?

Enclosure 8 - the final diagnosis in problem solving

In the table below, an innovative subprocess is presented, including the typical activities of the final diagnosis in the problem solving of executive consulting. It should be noted that in mental consulting, as opposed to executive consulting, the recommendations are part of the diagnosis. The objective of this diagnosis is preparing the advice stemming from the diagnosis. Output is the set of recommendations for problem solving, based on the diagnosis.

Table 8 of enclosure 8 - subprocess final diagnosis in problem solving (updated)

The activities of the subprocess "final diagnosis" in solving problems
What are the diagnostic facts in relation to the problems ?
What are the bases or evidence for the diagnostic facts ?
What are the diagnostic expert opinions in relation to the problems ?
What are the bases or evidence for the diagnostic expert opinions ?
What are the (revised) reported problems ?
What are the (revised) underlying causes ?
What are the (revised) maintaining processes ?
What are the consolidated draft findings regarding the problems ?
What is the feedback on the draft findings regarding the problems ?
What are the consolidated final findings regarding the problems ?
What are the draft recommendations for problem solving ?
What are the consequences from the draft recommendations for problem solving ?
What is the feedback on the draft recommendations for problem solving ?
What are the final recommendations for problem solving ?

LITERATURE

Anthony, S.D., 2017. *To Reinvent Your Firm, Do Two Things at the Same Time*. [podcast] Harvard Business Review Ideacast. Available at: <https://hbr.org/podcast/2017/04/to-reinvent-your-firm-do-two-things-at-the-same-time> [Accessed 20 July 2024].

APA, 2018. *Stress effects on the body*. American Psychology Organization. [online] Available at: <https://www.apa.org/topics/stress/body> [Accessed 19 June 2024].

Asadi, Ali M. Al., Klein B. and Meyer D., 2015. Multiple comorbidities of 21 psychological disorders and relationships with psychosocial variables. *Journal of Medical Internet Research*, March 2015.

Berendsen, A.H., 1991. *Als meer van hetzelfde minder is*. Post-doc thesis innovation (not published).

Berendsen, T. (A.H.) and Segers, J., 2020. *Turnaround-en crisisleiderschap. Een integratieve visie*. [pdf] Utrecht: Stichting Interacademiale Opleiding Organisatiekunde. Available at: <https://www.sioo.nl/wp-content/uploads/2020/05/Sioo-Whitepaper-Turnaround-en-Crisisleiderschap.pdf> [Accessed 13 June 2024].

Bijl, D., 2018. *Het pillenprobleem*. Amsterdam: Amsterdam University Press.

Blashfield, R.K., Keeley, J.W., Flanagan, E.H. and Miles, S.R., 2014. The cycle of Classification: DSM-I through DSM-5. *Annual Review of Clinical Psychology*, volume 10, pp. 25-51.

Bloom, B.S. ed., 1956. *Taxonomy of educational objectives. The classification of educational goals*. London: Longmans, Green and Co. ltd.

Boldrini, T., Tanzilli, A., Pontillo, M., Chirumbolo, A., Vicar, S. and Lingiardi, V., 2019. Comorbid personality disorders in individuals with an at-risk mental state for psychosis. *Frontiers in Psychiatry,* July 2019, volume 10.

Butler, A.C., Chapman, J.E., Forman, E.M. and Beck, A.T., 2006. The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, 26, pp.17-31.

CAMH, 2021. *Stress*. Centre for Addiction and Mental Health. [online] Available at: <https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/stress> [Accessed 23 June 2024].

Cleckley, H., 1955. *The mask of sanity: An attempt to clarify some issues about the so-called psychopathic personality.* 3rd ed. St. Louis: C.V. Mosby Com.

Clemson, 1997. *Stress Management for the Health of It*. [pdf] Clemson Extension. Available at: <https://nasdonline.org/static_content/documents/1445/d001245.pdf> [Accessed 15 June 2024].

Cohen, D., Quinn, B. and Roth, E., 2019. *The innovation commitment*. [pdf] McKinsey Quarterly. Available at:

<https://www.mckinsey.com/~/media/McKinsey/Business%20Functions/Strategy%20and%20Corporate%20Finance/Our%20Insights/The%20innovation%20commitment/The-innovation-commitment-vF.ashx> [Accessed 22 July 2024].

Cooper, C.L. and Quick, J.C. eds., 2017. *The Handbook of Stress and Health: A Guide to Research and Practice.* Hoboken: Wiley-Blackwell.

De Jong, M., Marston N. and Roth E., 2015. *The eight essentials of innovation*. [pdf] McKinsey & Company. Available at: <https://www.mckinsey.com/~/media/mckinsey/featured%20insights/innovation/the%20eight%20essentials%20of%20innovation/the%20eight%20essentials%20of%20innovation.pdf?shouldIndex=false> [Accessed 22 July 2024].

Deloitte, 2024. Deloitte AI Institute [online]. Available at: <https://www2.deloitte.com/nl/nl/pages/innovatie/topics/ai-institute.html?gad_source=1&gbraid=0AAAAAD-O-9vseBarluqdhsJ5SJQ6Oanxm&gclid=CjwKCAjwhIS0BhBqEiwADAUhc_8BhdO-YMK_8R-u589Isf4bENB-wLyRB2iyr1i0Enszghys81Qf2hoCNnwQAvD_BwE> [Accessed 20 July 2024].

De Smet, A, Gast, A., Lovoie, J. and Lurie, M., 2023. *New leadership for a new era of thriving organizations*. McKinsey Insights. Available at: <https://www.mckinsey.com/~/media/mckinsey/business%20functions/people%20and%20organizational%20performance/our%20insights/new%20leadership%20for%20a%20new%20era%20of%20thriving%20organizations/new-leadership-for-a-new-era-of-thriving-organizations.pdf?shouldIndex=false> [Accessed 18 June 2024].

Disc, 2023. *Disc The Complete Introduction*. [pdf] Manchester: Discus. Available at: <https://www.discusonline.com/en-us/features/free-guide-to-disc-personality-test.php> [Accessed 14 June 2024].

Disc, n.d. *Disc Theory and Research*. [pdf] Hoboken: Everything Disc, John Wiley & Sons, Inc. Available at: <https://www.everythingdisc.com/EverythingDiSC/media/SiteFiles/Assets/History/Everything-DiSC-resources-aboutdisc.pdf> [Accessed 14 June 2024].

DSM 2002. *Diagnostic and Statistical Manual IV TR*. 4th ed. Washington: American Psychology Association.

DSM 2013. *Diagnostic and Statistical Manual 5*. Washington: American Psychology Association.

DSM 2022. *Diagnostic and Statistical Manual 5 TR*. Washington: American Psychology Association.

Dutch Government 2024. *What is the state of mental health and psychosocial services (MHPSS) worldwide*. [online] Available at: <https://www.government.nl/topics/mhpss/mhpss-worldwide-facts-and-figures#:~:text=According%20to%20the%20WEF%2C%20poor,in%20MHPSS%20has%20economic%20benefits> [Accessed 17 June 2024].

Engel, G.L., 1977. The need for a new medical model: a challenge for biomedicine. *American Association for the Advancement of Science*, volume 196, pp.129-136.

Ericsson, K.A., Krampe, R.Th. and Tesch-Romer, C., 1993. The Role of Deliberate Practice in the Acquisition of Expert Performance. *Psychological Review*, volume 100, pp.363-406.

Eysenck, H.J., 2014. *The Structure of Human Personality*. 3rd ed. Abingdon: Routledge Taylor & Francis Group.

Freud, A., 1936. *Das Ich und die Abwehrmechanismen*. Wien: Internationaler Psychoanalytischer Verlag.

Frijda, N.H., 1988. *De emoties*. *Een overzicht van onderzoek en theorie. Amsterdam: Bert Bakker.*

Gu, S., Wang F., Patel, N.P., Bourgeois, J.A. and Huang J.H., 2019. A model for basic emotions using observations of behavior in drosophila. *Frontiers in Psychology*, April 2019, volume 10, article 781.

Gotzsche, P.C., 2013. *Deadly medicines and organised crime*. Boca Ratoni: Crc Press LLC.

Greiner, L.E., 1972. Evolution and revolution as organizations grow. *Harvard Business Review*, 1972, volume 50(4), July-August, pp.37-46.

Harvard Business Review, 2024. *Results search term "innovation"*. [online] Available at: <https://hbr.org/search?term=Innovation> [Accessed 18 July 2024].

Hayward, M. and Moran, P.A., 2008. Comorbidity of personality disorders and mental illnesses. *Psychiatry*, 7(3), pp.102-104.

Hazan, E., Madgavkar, A., Chui, M., Smit, S., Maor, D., Singh Dandona, G. and Huyghues-Despointes, R., 2024. *A new future of work: The race to deploy AI and raise skills in Europe and beyond*. [pdf] McKinsey Global Institute. Available at: <https://www.mckinsey.de/~/media/mckinsey/locations/europe%20and%20middle%20east/deutschland/news/presse/2024/2024%20-%2005%20-%2023%20mgi%20genai%20future%20of%20work/mgi%20report_a-new-future-of-work-the-race-to-deploy-ai.pdf> [Accessed 21 July 2024].

Hofmann, S.G., Asnaani, A., Vonk, I.J.J., Sawyer, A.T. and Fang, A., 2012. The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapeutic Research,* 36, pp.427-440.

ICMCI, 2024. *Navigating the Future: A Guide to AI in Management Consulting*. [pdf] Zürich: The International Council of Management Consulting Institutes. Available at: <https://www.cmc-global.org//sites/default/files/public/ai_white_paper_-_icmci_2024.pdf> [Accessed 19 July 2024].

Jack, R.E., Garrod, O.G.B. and Schyns, P.G., 2014. Dynamic facial expressions of emotion transmit an evolving hierarchy of signals over time. *Current Biology,* 24, pp.1-6, January 2014.

Jung, C.G., 1968. *The archetypes and the collective unconscious*. 2nd ed. New York: Princeton University Press.

Kahneman, D., 2012. *Thinking, Fast and Slow*. London: Penguin Books.

Kandel, E.R., Schwarz, J.H., Jessel, T.M., Siegelbaum, S.A. and Hudspeth, A.J., 2013. *Principles of Neural Science,* chapter 17, pp.383-386.

Kendell, R.E., 2002. The distinction between personality disorder and mental illness. *British Journal of Psychiatry*, 180, pp.110-115.

Kets de Vries, M.F.R. and Miller, D., 1984. *The Neurotic Organization. Diagnosing and Changing Counterproductive Styles of Management*. San Francisco: Jossey-Bass.

Kraepelin, E., 1899. *Psychiatrie. Ein Leerbuch für Studierende und Aerzte.* Leipzig: Universität Heidelberg.

Lan, L., Sikov, J., Lejeune, J., Chelsea, J., Brown, H., Bullock, K. and Spencer, A.E., 2023. A Systematic Review of using Virtual and Augmented Reality for the Diagnosis and Treatment of Psychotic Disorders. *New York: Current Treatment Options in Psychiatry*. [pdf] Available at: <https://link.springer.com/content/pdf/10.1007/s40501-023-00287-5.pdf> [Accessed 21 July 2024].

Lesser, R., 2024. *Five Truths (and One Lie) About Corporate Transformation*. [pdf] Boston Consulting Group. Available at: <https://media-publications.bcg.com/187-Weekly-Brief-Five-Truths-and-One-Lie-About-Corporate-Transformation.pdf> [Accessed 25 June 2024].

Machiavelli, N., 2011. *The Prince*. London: Penguin Books Ltd.

Marston, W.M., 2019. *Emotions of Normal People*. Read & Co. Science.

McKinsey, 2024a. *Results search term "innovation"*. [online] Available at:

<https://www.mckinsey.com/search?q=Innovation&pageFilter=all&sort=default&start=1> [Accessed 18 July 2024].

McKinsey, 2024b. *Environmental, Social & Government.* [online] McKinsey Sustainability. Available at: <https://www.mckinsey.com/capabilities/sustainability/how-we-help-clients/sustainability-and-social-impact-strategies/environmental-social-and-governance> [Accessed 22 July 2024].

McKinsey, 2024c. *100 articles on generative AI*. [online] McKinsey Insights. Available at: <https://www.mckinsey.com/featured-insights/themes/100-articles-on-generative-AI> [Accessed 21 July 2024].

McKinsey, 2024d. *Digital Insights*. [online]. McKinsey Digital. Available at: <https://www.mckinsey.com/capabilities/mckinsey-digital/our-insights> [Accessed 20 July 2024].

MHF, 2018. *Stress: Statistics. Results of our 2018 study*. Mental Health Foundation. [online] Available at: <https://www.mentalhealth.org.uk/explore-mental-health/statistics/stress-statistics> [Accessed 13 June 2024].

Mintzberg, H., Ahlstrand, B.W. and Lampel, J., 2009. *Strategy safari - your complete guide through the wilds of strategic management*. 2nd ed. Harlow: Pearson Education Limited.

Möller, H.J., Bandelow, B., Volz, H.P., Barnikol, U.B., Seifritz, E. and Kasper, S., 2016. The relevance of 'mixed anxiety and depression' as a diagnostic category in clinical practice. *European Archive of Psychiatry and Clinical Neuroscience*, volume 266, pp.725-736.

Oarue-Itseuwa., E., 2024. Artificial Intelligence's Impact of the Management Consultancy Sector over the Next Five Years. [pdf] *Management Consulting Journal*. Available at: <https://www.researchgate.net/publication/378096774_Artificial_Intelligence's_Impact_of_the_Management_Consultancy_Sector_over_the_Next_Five_Years#fullTextFileContent> [Accessed 23 July 2024].

Paris, J., 2020. *Overdiagnosis in Psychiatry. How modern psychiatry lost its way while creating a diagnosis for almost all of life's misfortunes*. 2nd ed. New York: Oxford University Press.

Paro, R., Grossniklaus, U., Santoro, R. and Wutz, A., 2021. *Introduction to Epigenetics*. New York: Springer.

Plutchik, R., 1962, *The Emotions, facts, theories and a new model*. New York: Random House.

PWC, 2024. *Discover new paths to future value* [online]. PWC. Available at: <https://www.pwc.com/gx/en/issues/artificial-intelligence.html> [Accessed 21 July 2024].

Rajakannan, T., Safer, D.J., Burcu, M. and Zito, J.M., 2016. *National Trends in Psychiatric Not Otherwise Specified (NOS) Diagnosis and Medication Use Among Adults in Outpatient Treatment*. [pdf] Available at: <https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201500045> [Accessed 14 June 2024].

Regier, D.A., Narrow, W.E., Clarke, D.E., Kraemer, H.C., Kuramoto, S., Kuhl, E.A. and Kupfer, D.J., 2013. DSM-5 field trials in the United States and Canada, Part II: Test-Retest Reliability of Selected Categories Diagnoses. *American Journal of Psychiatry*, 170(1).

Singla, A., Sukharevsky, A., Yee, L., Chui, M. and Hall, B., 2024. *The state of AI in early 2024: Gen adoption spikes and starts to generate value*. [pdf] McKinsey & Company and McKinsey Digital. Available at: <https://www.mckinsey.com/capabilities/quantumblack/our-insights/the-state-of-ai> [Accessed 21 July 2024].

Slagt, P., Burke, M. and Cochemé, A., 2024. *The Three Common Transformation Talent Mistakes and How to Avoid Them*. [online] Bain & Company. Available at: <https://www.bain.com/insights/the-three-common-transformation-talent-mistakes-and-how-to-avoid-them/> [Accessed 23 June 2024].

Spoorthy, M.S., Chakrabarti, S. and Grover, S., 2019. Comorbidity of bipolar and anxiety disorders. *World Journal of Psychiatry*, January 2019, volume 9, pp.7-29.

Stahl, S.M, 2021. *Stahl's essential psychopharmacology*. Cambridge: Cambridge University Press.

Stahl, S.M., 2024. *Stahl's essential psychopharmacology - Prescriber's Guide*. 8th ed. Cambridge: Cambridge University Press.

Statista, 2024. *Average company lifespan of S&P companies 1965-2030*. [online] Available at: <https://statista.com/statistics/1259275/average-company-lifespan/> [Accessed 1 July 2024].

Sun, J., Dong, Q.X., Wang, S.W., Zheng, Y.B., Liu, X.X., Lu., T.S., Yuan, K., Shi, J., Hu., B. and Han, Y., 2023. *Artificial intelligence in psychiatry research, diagnosis, and therapy*. [pdf] Available at: <https://pubmed.ncbi.nlm.nih.gov/37506575/> [Accessed 22 July 2024].

Tay, J.L., Xie, H. and Sim, K., 2023. *Effectiveness of Augmented en Virtual Reality-Based Interventions in Improving Knowledge, Attitudes, Empathy and Stigma Regarding People with Mental Illnesses - A Scoping Review*. [pdf] Journal of Personalized Medicine. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9864845/pdf/jpm-13-00112.pdf> [Accessed 23 July 2024].

Thagard, P., 2021. *Brain - Mind. From Neurons to Consciousness and Creativity*. Oxford: Oxford University Press Inc.

Thakkar, A., Gupta, A. and De Sousa, A., 2024. *Artificial intelligence in positive mental health: a narrative review*. [pdf] Frontiers in Digital Health. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10982476/pdf/fdgth-06-1280235.pdf> [Accessed 21 July 2024].

Vermani, M., Marcus, M. and Kathmandu, M.A., 2011. *Rates of detection of states and anxiety disorders in primary care: a descriptive, cross-sectional study*. Memphis: Physicians Postgraduate Press.

Wang, F., Pan, F., Shapiro, L.A. and Huang, J.H., 2018. Stress induced neuroplasticity and mental disorders. *Hindawi Neural Plasticity*, volume 2018.

WHO, 2023. [online] World Health Organization. Available at: <https://www.who.int/news-room/questions-and-answers/item/stress#:~:text=What%20is%20stress%3F,experiences%20stress%20to%20some%20degree> [Accessed 12 June 2024].

Widiger, T.A., 2011. Personality and psychopathology. *World Psychiatry,* 2011-10, pp.103-106.

Zorn, J.V., Schür, R.R., Boks, M.P., Kahn, R.S., Joëls, M. and Vinkers C.H., 2017. Cortisol stress reactivity across psychiatric disorders: A systematic review and meta-analysis. *Psychoendocrinology*, volume 77, pp.25-36.