Dubious diagnoses and the medicalisation of distress

When he started working as a psychotherapist James Davies had faith in psychiatry and deferred to the system. Now, as he explains to **Alan Pope**, he believes psychotherapists should stand up and say 'No!'

I first met Dr James Davies at a talk he gave to the Site for Contemporary Psychoanalysis in May. The title of his talk was 'The DSM: a great work of fiction?', which is taken from the heading of a chapter in his recently published book *Cracked: why psychiatry is doing more harm than good*. Davies had been asked to give this talk as the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) was to be published the following week. *DSM-5* was already causing controversy and the British Psychological Society (BPS) had expressed grave reservations in its pre-publication response.[1] I was profoundly shocked by what Davies had to say and immediately went out and bought a copy of his book. It makes for disturbing reading. Davies and I later arranged to meet to discuss his findings and its implications for the therapeutic community.

Alan Pope (AP): What inspired you to write *Cracked*?

James Davies (JD): When I first started working for the NHS I pretty much accepted the mainstream view that psychotropic drugs worked and that solid scientific processes established the categories of mental disorders. It took me many years of practice, research and independent reading to see that the mainstream view doesn't stand up to serious scrutiny. When I began to understand there was a massive gulf between what people had been led to believe, both in the profession and out, I realised that there was an important project to be undertaken. This was to bring these inconvenient facts to public attention and this is precisely what I wanted to do with *Cracked*.

AP: I think many of us have been uncomfortable about psychiatric diagnoses but nevertheless we have also believed that there was some sort of scientific evidence to back them up. What is shocking is that this is not the case at all and this is the starting point of the book.

JD: When I spoke to the people who put together *DSM-III* and *IV* – and it is *DSM-III* that really put *DSM* on the map – what was particularly shocking was that science only played a very minor role in how these categories were defined. The committee did have research but it was patchy and inconclusive, so the committee had recourse to what they called 'consensus'. They discussed what they thought should be included and if they agreed it went in. If they disagreed, they put it to the vote. And voting is not science!

AP: So what you are saying is that many of the categories are based on conjecture not scientific evidence?

JD: In modern, mainstream medicine a name will only be given to a disorder after pathological evidence has been found in the body. In psychiatry they work in completely the opposite way. They name the disorder without any biological roots in the body. This may account for the rapidly expanding number of disorders: 106 in 1950 and 374 today. It's far easier to name psychological disorders than to scientifically discover them.

AP: Mistrust of psychiatry has existed for a long time, in particular, as an agent of social control. Michel Foucault and Ken Kesey immediately spring to mind. I suppose we had hoped that psychiatry was now more benign. Reading your book, it doesn't feel that benign.

JD: I would agree. Homosexuality was originally included in *DSM* as a mental disorder but was removed in the mid-1970s. The inclusion was a way of stigmatising a section of the community because a particular group of people felt that their activities were morally suspect from their standpoint.

AP: There is an interesting point about that which may be more positive – the fact that the American Psychiatric Association (APA) voted to remove homosexuality as a disorder and, because of the power of *DSM*, it did make it more difficult for psychiatry, and indeed the world of psychotherapy, to act prejudicially towards homosexuals.

JD: Let's be clear, *DSM* didn't remove it. It was pressure from the American gay rights movement that made it impossible for them to keep it in. So it was outside forces that made them, rightly, remove it. However, now we find another very subtle form of social control, which may be to do with the economy under which we operate. Since the neo-liberal reforms of the 1980s under Thatcher and Reagan, productivity has become something that these economies want to foster. Anything that gets in the way of economic productivity has to be managed. Well, suffering and the decelerating distractions associated with it are deemed an inconvenience from the neo-liberal standpoint. So what we have seen over the last 30 years, I would argue, is the psychiatric industry trying to manage a suite of problems that are deemed economically inconvenient.

AP: And, in my view, that is precisely what the Improving Access to Psychological Therapies (IAPT) is about. One of its stated aims is to get people back to work and off benefits. A result of this is that psychological services at primary care level in the NHS are constantly monitoring benefits and employment, so that it feels like the NHS is part of the Department for Work and Pensions.

JD: So a form of social control still operates within psychiatry but along economic lines. This is another untold story that really needs to be written. We know from Freud in *Mourning and Melancholia* that psychoanalysis is like undergoing surgery without anaesthesia, and that sometimes you get worse before you get better and this process can take a long time. You have to give people that time; but from the standpoint of the interests of the neo-liberal economy, time is money. Hence the importance

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of funding short-term therapies that promise to get people back to work within 12 weeks. However, we are still waiting to see if that can be delivered. Short-term therapy is what gets funded because that's what works economically.

AP: So it's all about the economy?

JD: It's about the economy. We all agree that it's good for us to work and we want people to get back to work. The problem is that we have a one-size-fits-all approach that doesn't respect the individual's trajectory to recovery. What should be governing our clinical practice is not ticking boxes to please policy makers but doing things to aid a particular individual on their road to recovery.

AP: One of the things associated with *DSM* is the PHQ9 (Patient Health Questionnaire 9), which is now used uniformly within the NHS and has led to a vast increase in the prescribing of antidepressants.

JD: Yes, 46.7 million in England in 2011.[1] The PHQ9 is the diagnostic criteria for depression established in *DSM-III* by its chair Robert Spitzer, and the pharmaceuticals company Pfizer Inc owns the copyright. I would argue that the bar for clinical depression on the PHQ9 has been set very low, which leads to more people being diagnosed with the condition and therefore we see more people being medicated.

AP: On top of this, I think we all go to our GP and expect to come away with a prescription and feel rather cheated if we don't.

JD: Often people who want antidepressants are labouring under a misapprehension, largely fostered by the pharmaceutical industry, that they are suffering from a chemical imbalance that medication can correct. That theory has been around for about 60 years and there is no solid scientific evidence supporting its validity.[2,3] You have to have sympathy with people who demand these pills but that is one of the reasons I wrote *Cracked* to get the information out there. If they don't have that information they can't make an informed decision whether to take medication and right now they don't have that information.

AP: Interestingly, there was an article in the last issue of this journal by Diane Hammersley[4] that covers some of the same ground as *Cracked* about the effectiveness of antidepressants. In *Cracked* I was very struck by the information that you only need two positive clinical trial results for a drug to get licensed, no matter how many negative ones it may have had.

JD: It's actually worse than that. The MHRA (Medicines and Healthcare Products Regulatory Agency) in the UK only requires two positive clinical trials and will discard any others, five, 10 or 15, that are negative.[5] The arguments for doing that, I think, are very problematic and weak but they actually only require one if that one is deemed to be widespread and rigorous enough. When we look at the evidence from widescale meta-analyses of these clinical trials, which include all the discarded negative trials, we know that they work no better than placebos in between 80 to 90 per cent of patients.[6]

AP: When you say 'we know' – and this is part of the importance of your book – the 'we know' is actually very limited.

JD: Yes, you're absolutely right.

AP: What I think is important about *Cracked* is that it isn't written for this particular 'we'. It's written to be read by service users as well as mental health practitioners, but it is perfectly accessible to a general readership. I gave the book to a friend of mine who is not a mental health practitioner and he was riveted by it. He has quite a lot of experience of other people he knows taking antidepressants. What really struck a chord with him were the clinical descriptions of people whose personalities had been changed by taking antidepressants and how they had been 'deadened'. Another important aspect is that you have brought the issues and research together in one book.

JD: I think it was important to tell the whole story. To cover the construction of diagnostic categories and to show that the scientific evidence to describe these as biological problems simply isn't there. To turn our attention to the medications used to so-call treat these created disorders and to show how these medications are deeply problematic, often ineffectual and at times dangerous. Then to ask the question: Why are we prescribing ineffectual medications? Well, let's then look at the pharmaceutical industry and the enormous effect it's had on psychiatry in the last 30 years. What we then end up with is a picture of a self-serving industry with patients caught at the heart. I wanted to communicate that message to the people who are subject to that system. To do that I knew I would have to write in accessible language. Ultimately, they are the people who should have this information before they subject themselves to these sorts of treatments.

In writing the book my views changed greatly. When I started working as a therapist I took the line that many therapists take today, which is this: in combination, therapy and drugs are the best way of proceeding. I now believe that view to be completely wrong. Medications get in the way of therapy. They undermine the work we are trying to do. If you believe that part and parcel of someone's recovery is encountering and working through difficult feelings and emotions, medications that numb those emotions simply stop that process from unfolding. Another conflict we encounter is when working with clients who have been led to believe that their brain is in control here. How do you then get those clients to begin to subscribe to the notion that they are more in control of their lives than they have been led to believe? This really is the prerequisite to get

therapy to work: the assumption that therapy can work. Receiving a diagnosis can sometimes undermine that belief and lead to a fatalism in the client that, whatever they do, however hard they work, they are forever doomed to this biological misfortune.

AP: This leads us rather neatly to genetics, which is often expressed as, 'Well, my mother was depressed so it's obviously in the family, it must be in my genes!' I am fascinated by epigenetics, which I understand to be the latest development in this area. It shows that what happens to us affects our genes, rather than the other way round: our genes affecting us.

JD: Absolutely right. Fifteen years ago there was a hope that we would find specific genetic markers signifying specific disorders. That simply has not reached fruition. We now know from the development of epigenetics that there are molecules attached to the genes that either turn genes on or off depending on the environmental conditions to which that person is subject. What genetic research is now showing is that environment is key.[7] The fact that my mother and my grandfather had depression doesn't by any means substantiate the notion that I am genetically fated to follow them. Maybe the family culture has led to the development of this set of particular problems. When we look at this genetic research, it doesn't lead us to conclude that these problems can be reduced to genetic misfortune.

AP: This, actually, is good news for therapists for once. Increasingly, over the years, we have been told that science and pharmacology will provide the answer. This research confirms that what is important is the individual's narrative and the complexities in which it is lived. This is, of course, the material with which we work. Finally, how do you think practitioners can carry on the issues raised in your book?

JD: We need to better inform ourselves, that is the problem. Therapists are very busy; they don't have the time to read all this research, so are often beholden to the mainstream point of view. I certainly was. When I started work as a psychotherapist I believed in the system and I deferred to the system. I certainly didn't feel confident or secure enough to oppose some of the interventions that I saw psychiatrists undertaking. What we need now is an empowered psychotherapeutic community armed with the research and information they need to stand up to those to whom they had always deferred and say 'No!' in whatever form they want to do that. We need to become more politically active than we have been in the last 20 years. To do that effectively we need to have the research at hand. Again, that was another reason for writing this book – to give the practitioner the ammunition and backing to do something different.

Davies left me to join a discussion at the Houses of Parliament sponsored by the BPS about *DSM-5*. You may not agree with all he has to say but his book will provoke you to consider how we collapse the complex suffering of our clients into simplistic and sometimes stigmatising diagnoses. Indirectly, it begs us to ask ourselves: are we colluding in the over-prescription of psychotropic drugs whose effects are in most cases little better than placebos? ■

Alan Pope is a psychoanalytic psychotherapist and supervisor in private practice in London. He recently retired from working part-time in the NHS.

James Davies obtained his PhD in medical and social anthropology from the University of Oxford. He is also a qualified psychotherapist (having worked in the NHS), and a senior lecturer in social anthropology and psychology at the University of Roehampton, London. He has delivered lectures at many universities, including Harvard, Brown, CUNY, Oxford and London, and has written articles about psychiatry for the *New Scientist, The Guardian, The Times* and *Therapy Today*. He is author of *The Importance of Suffering: the value and meaning of emotional discontent* (Routledge, 2011). He lives with his wife and daughter in Shepherd's Bush, London.

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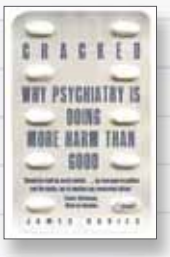

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