

Speaking our minds as clinical psychologists

Lucy Johnstone

A combination of international debates about psychiatric diagnosis, failure to find biomarkers to validate the 'illness' model, and emerging evidence on the role of trauma, abuse and social inequality in mental distress, is creating the possibility of fundamental change in mental health systems. However, despite the recent 'Position Statement on Classification', clinical psychologists have always had an ambivalent attitude to challenging psychiatric power and influence. This tension will be explored in relation to key areas of theory and practice.

IT HAS NEVER been more important to speak our minds as clinical psychologists. David Smail was certainly not afraid to do so. In fact, his statement '*I just know that the biological approach to psychological distress is bollocks*' (Smail, 1996) is increasingly relevant as this entire paradigm comes under threat.

Much of this controversy was brought to a head with the publishing of DSM-5. Chairs of current and former DSM committees and of the National Institute of Mental Health (NIMH) queued up to express their disapproval in the strongest terms. '*There is no reason to believe that DSM-5 is safe or scientifically sound... The science simply isn't there now... A research dead end*', said Dr Allen Frances, Chair of the DSM-IV Task Force. Dr Steven Hyman, former NIMH director, said DSM was '*totally wrong, an absolute scientific nightmare*.' Dr Thomas Insel, another former director of NIMH, stated '*Patients... deserve better... The weakness is its lack of validity*', and in a significant policy shift, '*NIMH will be re-orienting its research away from DSM categories*'. In response, Dr David Kupfer, chair of the DSM-5 committee, was forced to admit: '*We've been telling patients for several decades that we are waiting for biomarkers. We're still waiting*.' Allen Frances, using language as blunt as David Smail's, albeit from a rather different conceptual position, admitted: '*There is no definition of a mental disorder. I mean, you just can't define it. It's bullshit*' (Greenberg, 2012).

The furore has reached much more widely than this, to the extent that the whole future of psychiatry is regularly questioned. Mental Health Europe, a large umbrella organisation representing both professionals and service users, issued an article with the title 'Western psychiatry is in crisis' in which it deplored '*...the simplistic and imposed application of...reductionist science*' which can '*encroach on basic human rights*' (Mental Health Europe, 2013). In the *British Journal of Psychiatry*, there has been a series of articles on the theme of '*...whether the psychiatrist is an endangered species... Urgent action is required... to ensure the future of psychiatry as a profession*' (Oyebode & Humphrys, 2011).

The diagnosis debate is central to every other aspect of traditional psychiatric practice, since without a valid classification system, psychiatry would become '*...something very hard to justify or defend – a medical specialty that does not treat medical illnesses*' (Breggin, 1993). And yet every month brings new articles, often by psychiatrists themselves,

questioning the current nosology. '*If it becomes apparent that the information obtained by testing disease theories is incoherent, we may eventually jettison particular disease constructs... The disease constructs in psychiatry may be approaching this point*' (Bebbington, 2015).

Meanwhile, there is disturbing evidence that the mainstay of psychiatric intervention, medication, may in the long-term create more disability than it cures (Whitaker, 2010). And those who do manage to leave psychiatry behind frequently date their recovery from the moment they decided to give up their diagnoses. Core themes in recovery have been described as finding a new sense of connectedness; hope and optimism about the future; identity (including overcoming stigma); meaning in life; and empowerment (Leamy et al., 2011). Ironically, these are exactly the opposite of the messages frequently imparted by a diagnosis (Johnstone, 2014). We have to ask whether people are mainly recovering from the original 'illness', or from the labels that were imposed on them.

It is legitimate to summarise this state of affairs as Dr Sami Timimi, critical psychiatrist, recently did in *Clinical Psychology Forum*: '*It's hard to imagine such a record of harms could be tolerated in any other branch of healthcare, and it is hard to imagine how an ethical perspective can tolerate our use of the failed medical model paradigm in mental health any longer. It's time to reach beyond diagnostic dependence*' (Timimi, 2014, p.8).

This brings us to the main question: What are clinical psychologists doing about all this?

According to some, not much.

'We work in service systems largely based on a theoretical model which is more or less completely incompatible with ours. Heaven knows, we have bent over backwards to disguise this fact, to fit in, to appease, not to give offence. We have extensively adopted the language of medicine... we have described people in terms of an extraordinary range of deficits... we have eagerly adopted models such as the biopsychosocial model or the stress-vulnerability model, which make it easy for genes and biology to remain privileged... We have used the DSM framework to organise textbooks and much of our research and practice... The medical model remains dominant; we are graciously allowed to continue research and practice, provided we don't say or do anything too threatening... Why are we so timid in taking the lead?... Which are the truths we are still not speaking?' (Boyle, 2006).

Other clinical psychologists have also urged the profession to take a broader view.

'We see it as essential that psychologists... have a critical and questioning perspective on the values and practice that dominate mental health services and psychology... Whilst we believe that our profession can contribute to obscuring and individualising people's experiences, we also believe it has much to offer in terms of explanations of human despair' (Coles, Diamond & Keenan, 2009).

'An overwhelming amount of evidence tells us that as clinical psychologists we cannot afford to ignore the context of social inequality and injustice in our work, for scientific as well as ethical reasons. This will inevitably also involve us in challenging, not colluding with, some of the core tenets of biomedical psychiatry. In this way we will be facing ethical dilemmas head on, wherever we work, and fulfilling our moral and professional responsibilities as clinical psychologists' (Johnstone, 2011).

So, what stops us from doing this? Are we too comfortable in our position of high pay and high status, to risk speaking our minds? Do we challenge, compromise or avoid (Johnstone, 2011) in relation to dilemmas about the fundamental issues in mental health work – diagnosis, biomedical models, the use of medication, the role of social inequality and deprivation, and the application of what might be called 'medical model psychology' solutions to complex social problems? The IAPT programme is one example of the latter – which attracted David Smail's memorable comment *'...this kind of bureaucratised 'science' peddled by NICE is exactly the kind of thing a healthy and independent clinical psychology, in charge of its own soul, would criticise, not endorse'* (Smail, 2006).

There are no simple answers to the challenge, compromise or avoid dilemma. It is impossible to be part of the mental health system without, at times, colluding with damaging practice. Equally, few of us can sustain whole careers at the sharp end of mental health work – we may need to have periods of 'avoidance' to preserve our family lives and sanity. We also need to be honest about the fact that there is often a high price to be paid for speaking out – whether in terms of opposition from colleagues, hostility on social media, or career progression.

At these times, it may be useful to bear in mind Gandhi's saying: 'First they ignore you, then they fight you, then you win.' There is plenty of evidence of the middle stage of this process in relation to some of the bold steps the profession has recently taken. Here is a commendable example of speaking out – the DCP/BPS response to the DSM-5 proposals:

*'Clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation... The putative diagnoses presented in DSM-5 are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgments, with few confirmatory physical 'signs' or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations.'*¹

There were strong reactions, both positive and negative, to the DCP Position Statement on Classification which called for the end of diagnosis and the 'disease' model of mental distress, including national coverage in *The Observer* on 12 May 2013. The same was true of the ground-breaking publication *Understanding Psychosis and Schizophrenia* (2014) which has as its central theme:

'Hearing voices or feeling paranoid are common experiences which can often be a reaction to trauma, abuse or deprivation. Calling them symptoms of mental illness, psychosis or schizophrenia is only one way of thinking about them, with advantages and disadvantages' (BPS, 2014, p.6).

Among the more bizarre accusations were that it *'...exploits, disrespects, silences and marginalises service users... Understanding Psychosis and Schizophrenia should be seen as a cruel hoax perpetrated against more typical severely disturbed mental health service users, their family, and policymakers.'*

It is hard to see how such a reasonable position, in a publication co-authored with service users, could have aroused such a degree of ire in some quarters, but clearly this is a sign of a nerve being hit. We can expect, and even welcome, this kind of response as a sign that we are finding our voice as a profession and are willing to 'speak truth to power.'

Another hidden truth concerns the causal relationship between deprivation, inequality and all forms of mental distress. Clinical psychologists should remember that best practice principles of their core professional skill, psychological formulation, clearly require us to locate mental distress within its wider social contexts. The DCP Good Practice Guidelines quotes the WHO to the effect that *'[l]evels of distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice'* (WHO, 2009.) One of the best practice criteria for a formulation is that it should *'[h]ave a critical awareness of the wider societal context within which formulating takes place, even if this dimension is not explicitly included in every formulation'* (DCP, 2011, p.20).

¹ <http://www.bps.org.uk/system/files/consultationpapers/responses/DSM-5%202011%20-%20BPS%20response.pdf>, p.2.

We also have reason to be proud of our role in researching, promoting and implementing alternative models of distress, and specifically the so-called 'trauma-informed' perspective. This explicitly recognises the causal role of trauma and adversity of all kinds in all human organisations and systems, and re-conceptualises psychiatric 'symptoms' as understandable, indeed adaptive, responses to threat which may have outlived their usefulness. A trauma-informed environment seeks to establish safety and avoid re-traumatising across all diagnostic presentations, setting the scene for trauma processing work and eventual re-connection with one's life and community (www.asca.org.au).

A trauma-informed formulation '[c]onsiders the possible role of trauma and abuse' and '[c]onsiders the possible role of services in compounding the difficulties' (DCP, 2011, p.14). Trauma-informed formulations can help us to make sense of people's distress, to bear witness to survivors' stories, and to develop a shared framework for recovery. The meta-message of a best practice psychological formulation is: 'You are experiencing a normal reaction to abnormal circumstances. Anyone else who had been through the same events might well have ended up reacting in the same way.'

As clinical psychologists, it is our duty and our privilege to support service users in this way. In the words of Judith Herman:

'The knowledge of horrible events periodically intrudes into public awareness but is rarely retained for long... Clinicians know the privileged moment of insight when repressed ideas, feelings, and memories surface into consciousness... Victims who have been silenced begin to reveal their secrets... Survivors challenge us to reconnect fragments, to reconstruct history, to make meaning of their present symptoms in the light of past events' (Herman, 1992, p.2).

And in the words of David Smail:

'I've always thought that psychologists and people in the helping professions generally can be pretty chicken-hearted when it comes to political issues. I should re-phrase that probably, it's not because they are cowards, or they are anything reprehensible... it's because people who come into this kind of job are on the whole menders and compromisers or believers in being nice to people... and I think when you get down to political activities with a small p those aren't the most useful characteristics. You've certainly got to be able to be diplomatic, you've got to be able to see where the lines of influence run, but you've got to be prepared to stick your neck out when it matters' (Moloney, 2012).

It matters.

The Author

Lucy Johnstone, Consultant Clinical Psychologist, Author and Independent Trainer.
Email: Lucyjohnstone16@blueyonder.co.uk

References

- Bebbington, P.E. (2015). A commentary on Kendler. *Psychological Medicine*, 45(6), 1119–1120.
- Boyle, M. (2006) Speaking the truth about ourselves. *Clinical Psychology Forum*, 168, 4–6.
- Breggin, P. (1993). *Toxic psychiatry*. London: Fontana.
- British Psychological Society (2014). *Understanding psychosis and schizophrenia*. Leicester: British Psychological Society.
- Coles, S., Diamond, B. & Keenan, S. (2009). Clinical psychology in psychiatric services. *Clinical Psychology Forum*, 198, 5–10.
- Division of Clinical Psychology (2011). *Good practice guidelines on the use of psychological formulation*. Leicester: British Psychological Society.
- Greenberg, G. (2012). Inside the battle to define mental illness. *Wired*, 27 October 2012. Retrieved from: http://www.wired.com/magazine/2010/12/ff_dsmv/
- Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
- Johnstone, L. (2011). The clinical psychologist. In P. Barker (Ed.) *Mental health ethics: The human context*. London: Routledge.
- Johnstone, L. (2014). *A straight talking introduction to psychiatric diagnosis*. Ross-on-Wye: PCCS Books.
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, 199, 445–452.
- Mental Health Europe (2013). *More harm than good: DSM 5 and exclusively biological psychiatry must be completely rethought*. Retrieved from: http://www.mhe-sme.org/news-and-events/mhe-press-releases/dsm5_more_harm_than_good.html
- Oyebode, F. & Humphries, M. (2011). The future of psychiatry. *British Journal of Psychiatry*, 199, 439–440.
- Smail, D. (1996). J. Richard Marshall. *Clinical Psychology Forum*, 95, 14–16.
- Smail, D. (2006). Is clinical psychology selling its soul (again)? *Clinical Psychology Forum*, 168, 17–20.
- Timimi, S. (2014) First do no harm. *Clinical Psychology Forum*, 261, 6–7.
- Moloney, P. (2012). *Interview with David Smail*. Retrieved from <http://www.davidsmail.info/moloney.htm>.
- Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown Publishing Group.
- World Health Organisation (2009). *Mental health, resilience and inequalities*. Copenhagen: WHO Regional Office for Europe.