Examination of Psychiatric Diagnosis through a Social and Critical Lens

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METAPHYSICAL vs EPISTEMOLOGICAL vs SEMANTIC TRUTH

Are all mental illnesses real?

Which mental illnesses are real?

What is the construct validity of schizophrenia? What is the construct validity of Bipolar I, Bipolar II Disorder? What is the construct validity of PTSD? ADHD? Major Depression?
THE SCRIPT

• I AM NO PHILOSOPHER, SIMPLY A FRUSTRATED PSYCHIATRIST

• CRITICAL THEORY AND CRITICAL PSYCHIATRY

• FIRST, MJ and WAKEFIELD, JC – DEFINITION OF MENTAL DISORDER IN DSM-5, QUESTION OF FALSE POSITIVES

• HIGH AND LOW PREVALENCE DISORDERS

• CRITICAL LITERATURE ON OVERDIAGNOSIS OF DEPRESSION, BIPOLAR II, PTSD, ADHD, AUTISM SPECTRUM DISORDER
STICK TO THE SCRIPT

• HOW HAS IT BECOME SO BAD? INFLUENCE OF PHARMACEUTICAL INDUSTRY

• MENTAL HEALTH WORK AND THE PROFESSIONS

• NEOLIBERALISM – THE COMMODIFICATION OF MENTAL HEALTH

• HOW DOES THIS FIT WITH VALUES BASED PRACTICE?

• DOES IT HELP RECOVERY?

• CONCLUSIONS: ‘THE BOUNDARY PROBLEM’; SHOULD ‘NORMAL’ BE SAVED? CAN IT BE SAVED?
CRITICAL LENS: CRITICAL THEORY
SOCRATES - FIRST WESTERN CRITICAL THEORIST

- He subjected long-standing beliefs to rational scrutiny and speculated about concerns that projected beyond the existing order.
- Condemned by the Athenian citizenry for corrupting the morals of the young and doubting the gods.
IMMANUEL KANT – CRITICAL PHILOSOPHY

- Prominent Western Philosopher (1724 – 1804)
- ‘Reason is the source of morality’
- ‘Moral autonomy is the highest value for the individual’
- The primary task of philosophy as criticism rather than justification of knowledge
- Criticism, for Kant, meant judging as to the possibilities of knowledge before advancing to knowledge itself
CRITICAL THEORY

- Conceived from the Intellectual Crucible of Marxism
- Refuses to identify freedom with any institutional arrangement or fixed system of thought.
- Little use for ‘perennial philosophy’
- Questions the hidden assumptions and purposes of competing theories and existing forms of practice
- Developed between WWI and WWII (Adorno, Horkheimer, Marcuse, Habermas)
- Its representatives would wage an unrelenting war on the exploitation, repression and alienation embedded within Western civilization (Bronner 2011)

• ‘Mental Illness, *we are told*, is a major problem of our time.’

• But what exactly is this problem, and why do we seem so bad at solving it?
• Achieving expanded reimbursement by misdiagnosing normal distress as mental disorder is justified even if one is helping non-disordered patients who need and deserve help has become a common ethical issue that I label the “clinician’s dilemma” Wakefield JC. Psychological justice: DSM-5, false positive diagnosis, and fair equality of opportunity. Public Aff. Q. 29(1):32–75

• What does the mental health diagnosis mean to the person who owns it
  • Especially ‘high prevalence’ disorders? Are we always helping?
‘DSM-V Task Force was relatively tone deaf to validity issues of over-labelling normal distress as mental disorder’

As psychiatry moved from the hospital and asylum to the community, the challenge (has been) to distinguish disorder from the immense normal distress present in the community.

Significant expansion in the category of Z codes
• Attenuated Psychosis Syndrome – Boundaries of psychosis
• ADHD: one in five high school boys, 11% of all US schoolchildren have been diagnosed with ADHD, 2/3rds of them taking stimulant medication
• MDD: Elimination of Bereavement Criterion, “Already bloated beyond plausibility”
• Bipolar I: ‘abnormally and persistently increased activity or energy’ – reduce the number of ‘irritability’ false positives, DDx: Borderline PD
• Bipolar II and PTSD
• Psychological Factors Affecting Other Medical Conditions, Binge Eating Disorder, Intermittent Explosive Disorder, Mild Neurocognitive Disorder
• Substance Use Disorder: 2 out of 11 criteria for a diagnosis of mild SUD
HIGH AND LOW PREVALENCE PSYCHIATRIC DISORDERS

• High Prevalence: Anxiety and Depression, ADHD, Post-Traumatic Stress Disorder

• Low prevalence: Schizophrenia, Bipolar I, Organic Disorders, Psychiatric manifestations of Intellectual Disability

• Substance Use Disorders and Addiction Psychiatry

• Bipolar II Disorder:

• No sound evidence for an epidemic of depression (as psychiatric disorder) in the UK

• However, the case for an epidemic of antidepressant prescribing is now cast iron

• In spite of unrobust evidence base

• ANTIDEPRESSANTS WILL NOT CURE HUMAN MISERY
SUMMERFIELD CONTD.

• ‘Depression’ has no exact equivalent in non-Western cultures

• Do not share a Western ethnopsychology that defines ‘emotion’ as biological, internal, unintentioned, distinct from cognition, and a feature of individuals rather than situations.

• Non-Western peoples would tend to see the problem in situational and moral terms

• There is no such thing as depression, if by this we mean (as the WHO) a unitary, universally valid, pathological entity requiring medical intervention.

• One clear-cut beneficiary from such claims is the pharmaceutical industry
A new and flexible notion of the condition has been created that bears little resemblance to the classical condition, and that can easily be applied to ordinary variations in temperament.

‘The expansion of bipolar disorder, like depression before it, medicalises personal and social difficulties, and profoundly affects the way people in Western nations conceive of what it means to be human’

Transcultural Psychiatry 51: 4:p 581-598
• Commonest referral from GPs: ‘Depression’ – not responding….?Bipolar II

• If you say yes, the risk is that the patient will then do the rounds of biomedical psychiatry for years

• Is this ‘medicalization’ helpful for ‘recovery’?
SUMMERFIELD on PTSD


• METROPOLITAN POLICE BLUES: PROTRACTED SICKNESS ABSENCE, ILL HEALTH RETIREMENT, AND THE OCCUPATIONAL PSYCHIATRIST BMJ 2011;342:d2127

• The constructs of “psychology” or “mental health” are social products

• Reflecting on his time as consultant occupational psychiatrist to the Metropolitan Police Service, he found that sickness absence on mental health grounds had roots both in organisational culture and in broader cultural trends across society
SOCIAL LENS: SOCIOLOGY OF THE PROFESSIONS

- Mental health work and the professions
- Neo-Durkheimian framework
- Neo-Weberian
- Neo-Marxian
- Post-structuralist
THE FOUNDERS OF MODERN SOCIAL SCIENCE

Durkheim (1858 - 1917)

Weber (1864 - 1920)

Marx (1818 - 1883)
• Study of professions by sociologists
• Claims of special knowledge and altruism taken at face value
• Static or stable providing social cohesion
• A source of community for one another, stability for the wider society
• Regulate their own practitioners, ensuring good practice, establishing codes of conduct, punishing errant colleagues
NEO-WEBERIAN FRAMEWORK

- Professionals develop strategies to: advance their own social status, persuade clients about the need for the service they offer
- Corner the market in that service and exclude competitors.
- Two notions:
  - Social closure
  - Professional Dominance
NEO-WEBERIAN FRAMEWORK FOR THE PROFESSIONS
CONTD: SOCIAL CLOSURE

• Only those inside the boundaries of the profession can scrutinize its practices

• To maintain their social status they must convince others they are offering a unique service

• Develop various rhetorical devices to persuade the world at large of their special qualities

• They must justify a peculiar knowledge base that has a technical or scientific rationality on the one hand

• On the other, is not so easy to understand that anybody can use it
NEO-WEBERIAN FRAMEWORK CONTD.

- **Professional Dominance:**
  - They have power over their clients
  - Professionals exercise power over new recruits
  - Professionals seek to establish a dominant relationship over other occupational groups working with the same clients

- **Power relationships are of central importance to neo-Weberians**

- **Horizontal relationships** between professionals and those they work with, in order to sustain the material advantages, status and comforts of middle-class life in society
NEO-MARXIAN FRAMEWORK

- Power relationships important but focus on vertical structural relationships
- Capitalists/bourgeoisie
- Marx gave scant attention to the ‘white collar’ workers who were neither exploitative capitalists nor workers
- Contradictory position of professionals in capitalist society
- ‘They are not capitalists but serve the interests of the latter’
ETHICS OF NEOLIBERALISM

• Mental disorders become viewed as conditions largely divorced from social, economic, and political contingencies and turned into personal pathologies that can allegedly be treated through the value-free traditions and naturalistic methods of science and medicine.

• Esposito, L & Perez, FM 2014, 'Neoliberalism and the Commodification of Mental Health', *Humanity & Society*, vol. 38, no. 4, pp. 414-42.
ECLECTICISM AND POST-STRUCTURALISM

• It is common for sociologists to draw on more than one theoretical tradition: Eclecticism

• **Post-structuralism** goes beyond eclecticism

• Michel Foucault and his followers

• Notion of discourse includes both **forms of knowledge and the practices associated with that knowledge**
POST-STRUCTURALISM

Notion of ‘discursive practices’

Power is dispersed, it cannot be simply and easily located in any elite group

Bound up with dominant discursive features of a particular time and place, these may change and be resisted

In the post-structuralist account there is a failure to endorse the notion of self-conscious collective activity of professionals, to advance their own interests or to act on behalf of the capitalist state
VALUES BASED PRACTICE

• Values in the discipline of Psychiatry
• Relationship between Values Based Practice and Science, Values Based Practice and Philosophy
• ‘Boundary Problem’ – e.g. boundary between mental disorder and delinquency
RECOVERY

• Originated from concepts related to recovery from serious/severe mental illness
• In SMI, not about going back to pre-illness state
• Different from the ‘old’ emphasis on controlling symptoms or cure
• Both a ‘process’ and an ‘outcome’
• Q: Recovery from High Prevalence Disorders?
• Keywords: strength, self-agency, hope, interdependency and giving, systematic effort which entails positive risk taking, RESILIENCE
LIMITS TO MEDICINE. MEDICAL NEMESIS. THE EXPROPRIATION OF HEALTH by IVAN ILLICH (1975)

- Commodification of people’s health
- Clinical Iatrogenesis – injury done to patients by ineffective, toxic and unsafe treatments
- Social Iatrogenesis - Medicalisation of life. More and more of life’s problems are seen as amenable to medical intervention
- Cultural Iatrogenesis - destruction of traditional ways of dealing with and making sense of death, pain, and sickness.
- Rather extreme viewpoint, but some merit in the first two arguments in relation to psychiatry
CONCLUSIONS

• Discussions regarding psychiatric diagnosis need to evolve
• High Prevalence vs Low Prevalence Disorders – issue of False Positives
• Mental distress (Z categories) vs Mental Illness vs Mental Disorder
• Distress in a Dystopian global world
• This fits in with the neo-liberal reality of employment opportunities continuing to become scarce while "severe economic crises continue to erupt as a feature of capitalist modernity, as well as the existence of mass poverty and structural exploitation on a global scale" (Postone 2015). The Task of Critical Theory Today: Rethinking the Critique of Capitalism and its Futures
CONCLUSIONS (2)

• Who are the Reflective Practitioners? Most don’t seem to be bothered much.
• Is there actually a ‘clinician’s dilemma’?
• Sociological (Neo-Weberian or Neo-Marxian) understanding of the profession.
• Current service user involvement and co-production – indicative that post-structuralist ideas are gaining ground