Psychiatry: Science or Scientism? The inevitability of overdiagnosis

It is the theory that determines what is observed

– Albert Einstein

Derek Summerfield's recent BMJ article[1], portraying the overuse of psychiatric diagnosis and language, reignites a very old debate. Fifty years ago, three writers in particular – Laing, Illich and Szasz[2] – together with activist groups such as People Not Psychiatry, warned us of the traps of unwisely medicalising our mental health and welfare and the price we might pay. Summerfield's brief contemporary analysis largely endorses these much earlier critics.

Fundamental to these deeply-rooted problems is our overuse, or misuse, of the medical model, and then its mindset, language and interventions – its diagnoses and treatments. This excess and misapplication has evolved largely because of the massive previous successes of the scientifically centred medical model. In the last century it has been spectacular at eliminating, preventing or minimising many previously lethal or crippling physical illnesses. Medical interventions have often unfurled almost Olympian powers over the fate of humanity.

But this success has its dangers: from these indisputable achievements we have all too readily segued to grand-scale misassumptions. We have often wished to believe that *all* problems presenting to healthcarers could be similarly processed and solved: by expediting our procedures of objectification-diagnosis-treatment. This is consistent with our increasingly technology-dependant lives: almost all that we encounter now is similarly manufactured, standardised, packaged and despatched for our use. So why not

expect equivalent psychological or psychiatric *treatments* to fix our myriad forms of personal and social dis-ease?

Then can we not recruit specialists to fix all our distress and ailments? In particular, to fix our illimitable stress-related and mental health problems?

The misassumption here is crucial: it is that our medical model can be effectively and reliably transferred to, and then mass-produced for, problems that are human rather than biomechanical. This crucial distinction – the human *v* the biomechanical – corresponds very well to what can be objectively observed and measured, and what cannot. And here begin our many problems of medical modelling throughout pastoral and mental healthcare: this is because we cannot directly measure any experience, for example 'depression', with the same reliability or precision as, say, left ventricular output or serum calcium[3]. Rigorous and insistent attempts to do so draw us away from true science and into the capricious, yet often authoritarian, realm of scientism: those activities that are attired like science, but which underneath are not and cannot be. Summerfield's lament of this is trenchant and topical, yet is also a long-delayed echo of our 1960s' and 1970s' prophetic luminaries.[2]

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We can help ourselves greatly here by considering the difference between scientific *attitude* and scientific *activity*. For scientific attitude (dispassionate observation, patterning a hypothesis and prediction; further observation to refute/confirm/reformulate the hypothesis etc) is essential to all intelligent life, certainly any successful human engagement. So our work always needs to be guided by a scientific attitude. But this is

very different to submitting to protocols for scientific *activity*, which is characterised by standardised measurements, schemata and language. The failure to heed this distinction has led to many doomed projects in pastoral healthcare: in particular, mental health services becoming so often in thrall to institutional scientism while increasingly depleted of human sense and sensibility.[4] Summerfield is thus readily able to point out the inevitable lack of scientific integrity in psychiatry.[1]

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So why have we done this? A brief answer is both ideological and expedient – we have thought we either should or could industrialise and proceduralise our way out of our myriad, tricky human and societal problems by medicalising (and medicating) them. After all, that is the way – mostly – our commodified world works for us now.

And how have we done this? Increasingly by making such poorly grounded science – and then its often shallow or flawed data – the dominant, and often only, currency and language in the NHS.

From the 1980s, coincidental with the first stirrings of marketisation, there have been successive medically modelled reforms of mental health services. These have been designed to short circuit and administratively eliminate the essential human ambiguities so carefully considered by earlier writers and practitioners. Summerfield now describes the ballooning number of sub-specialties, diagnoses[4] and prescriptions.[5] Few (non-management) veteran observers or practitioners would say that – overall – these expensive changes constitute progress in the quality of our care and understanding.

Not everything that can be counted counts; not everything that counts can be counted.

– Albert Einstein

Shortly before this accelerated hegemony of misassumptions we had another wisely prophetic book, *Psychiatry in Dissent*,[6] by Anthony Clare. It was published in 1976 and so was a kind of swan-song for a culture and health service still permeated by intelligent doubt and searching philosophy. But this erstwhile kind of space – for practitioner reflection and relativism – has been driven out by subsequent managerialism that is insistent on administrative uniformity and clarity but is then inimical to human complexity, variation or experience: instead we have, increasingly, been instructed to proceed by medically-modelled pastoral and mental healthcare.

The result so often is what Summerfield describes: the pullulating of new specialisms, diagnoses and treatments applied by increasingly stressed, alienated and unviable services all clamouring for funding. Summerfield is right, too, in suggesting we must counter these with broader mindsets and languages. Often it is more humane, and eventually more effective (and so more economic) to retranslate the speciously biotechnical back into the language of the personal and the social.

Our excessive, and rapidly increasing, anti-depressant prescribing – the anchored centre of Summerfield's articles – is but the tip of an enormous iceberg.

Notes and references

1. Summerfield, D 'NHS antidepressant prescribing – what do we get for £266 million per year?', *British Medical Journal* Blog, 27.2.18

2. The following three books are seminal, some would say iconic, from that time. None can instruct us how to run a modern mental healthcare service: yet all contain vital caveats for what we now can (and do) get very wrong:
    - Laing RD (1960), *The Divided Self. An Existential Study in Sanity and Madness*. Penguin.
    - Illich, I (1975), *Limits to Medicine. Medical Nemesis. The Expropriation of Health.* London: Marion Boyars.
    - Szasz, T (1961), *The Myth of Mental Illness. The manufacture of madness*. Harper Collins.
3. Zigmond, D (1976). 'The medical model. Its limitations and alternatives. How humanism may synergise biomechanism'. *Hospital Update*, August, 424-427
4. Zigmond, D (2015) 'Sense and Sensibility'. *If You Want Good Personal Healthcare – See a Vet*, Section 2, Chapter 10. New Gnosis Press.
5. Summerfield, D (2006) 'Depression: epidemic or pseudo-epidemic?', *Journal of the Royal Society of Medicine*, 99: 161-2
6. Clare A (1976) *Psychiatry in Dissent. Controversial Issues in Thought and Practice*. Tavistock Press.