C H A P T E R THIRTEEN

An Ethical Enquiry that Questions whether Psychiatrists truly are Mental Health/Disability Experts? Reasons to Doubt!

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A crisis of confidence regarding Psychiatry exists even among psychiatrists themselves. Psychiatry has a checkered history and its alliance with the pharmaceutical industry, aka Big-Pharma, continues to reinforce a need for healthy skepticism. Fundamentally there is an over-reliance on the questionable expertise and authority afforded psychiatrists as the specialists of mental health. I contend that the authority of psychiatry is misplaced and too often, harmful. Since the criteria required to justify and satisfy psychiatric expertise is not fully established as can be substantiated by compelling reasons to rethink its authority as a reliable profession in its current form. Psychiatric expertise is not particularly scientific and this is especially dangerous in a sector that prescribes psychoactive drugs. There are a number of identified criteria that would otherwise substantiate psychiatric expertise and whilst partially existent, are nonetheless deficient. These major yet deficient aspects of psychiatric practice concern diagnostic problems – reliability and verification of diagnoses and accurate testable validity of diagnoses - mainly due to an absence of identifiable underlying biomarkers ordinarily related to disease or biological conditions. Psychiatrists often fail to distinguish between reactive-depression (reaction to external event or circumstance) and endogenous-depression (biological) resulting, in part, from incorrectly distinguishing between conditions constitutive of 'trait' (endogenous) and of those of 'state' (e.g. reactive depression; adverse effects from medication, etc.).

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A crisis of confidence regarding Psychiatry exists even among psychiatrists themselves. Psychiatry has a checkered history and its alliance with the pharmaceutical industry, aka Big-Pharma, reinforces a need for healthy skepticism. Why? An over-reliance on the questionable expertise and authority afforded psychiatry as the specialists of mental health. Psychiatrists, in many ways, not only determine what mental illness is but also what and how treatment is administered

to those deemed afflicted. The presumption that this authority is based on expertise can have a profound effect on people and so requires detailed attention. Psychiatrists can enforce the Mental Health Act across jurisdictions and compel hospital admissions, and if so determined, seclusion and restraint within hospital; an authority which extends to private care-residency facilities, and far too often, and way beyond responsible clinical requirement, the excessive administration of psychoactive drugs. Psychiatrists, generally, are sought after to offer opinions concerning people's capacities to rationally make financial and medical decisions, moreover to provide opinions regarding whether someone requires hospitalisation or prison (Badre, Barnes, Lehman & Steingard, 2019, pp. 155-156). On close examination however psychiatric expertise is imprecise, broadly at variance among its own rank and file, too often unreliable, marred by methodological diagnostic deficiencies (Phillips, 2015 p. 164); thus arguably, justified concern symptomatic of its own reliance on a less than robust methodological framework. Despite extensive research the most significant finding is a "failure to delineate the pathophysiology of the major psychiatric disorders, and the corresponding failure to find biomarkers for these disorders" (Phillips, 2015 p.164). So, why is psychiatry regarded as a specialist profession that wields medical authority, which has become increasingly relied upon for its presumed expertise in both mental health and disability service sectors and across their governing institutions? Over the last twenty-five years there has been a proliferation of work that continues to emerge that questions the underpinning assumptions of psychiatric knowledge and practice. "This work, appearing as academic papers, magazine articles, books, and chapters in books, has not been written by academics, sociologists or cultural theorists. It has emerged from the pens and practice of a group of British psychiatrists" (Thomas, 2013). In fact, the movement has increasingly grown to incorporate psychiatrists and associated clinicians and researchers in America, Australia, New Zealand, and throughout Europe.

People with lived-experience tell a different story to that found in the literature funded by the pharmaceutical industry. Moreover, the literature on research studies investigating the long-term effects of psychiatric drugs, identifying the range and scale of adverse effects (iatrogenic damage) from antipsychotics (neuroleptics) and antidepressants, provide cautionary and often contrary accounts to that found in psychiatric journals (Dorozenko and Martin, 2017).

A qualification is required here to acknowledge that many people benefit from psychiatric services and from the administration of psychiatric drugs particularly when the condition being treated is in fact endogenous. Though one should not doubt that for many individuals there is an interplay of environmental and psychological factors that trigger dysfunction amplified by the combination of stressors, or even, if at times, these may occur in isolation (Preston & Johnson, 2019). Real benefit is gained by individuals, more so, when treated on a short-term basis, in most instances, without the need for drugs. Longitudinal studies show that long-term use of antipsychotics and antidepressants produce more damage than benefit for the consumer both financially and at the expense of genuine good health (Breggin, 2013; Davies, 2013; Gøtzsche 2013; Moncrieff, 2008; Szasz,

2010; Whitaker, 2015). Controversy surrounds the inherent problems associated with the professional and clinical education psychiatrists are receiving. Mental health should be considered along a continuum such that practitioners need to be qualifying to what extent a disorder comes about by psychological factors or whether there really is empirical evidence that supports the notion of biochemical disturbance at play (Preston & Johnson, 2019).

Accordingly, this essay focuses on the profession of both biological psychiatry and psychological psychiatry, relative to the constitutive development of expertise, as understood as the subject of psychological investigation, examined through a comparative analysis with medicine in general. The methodology employed is a critical examination of the historical literature of psychiatry, of expertise, of relevant medical advances, and of contemporary studies into the practice of psychiatry. The process unfolds through an examination of the criteria required to establish subject or profession related expertise to then consider the reliance on psychiatric expertise and the identifiable implications of such reliance as it plays out in society and interrelated institutions and services. The ethical perspective underpinning the research for this essay is the Common Theory of Morality as articulated by Beauchamp and Childress (2009). From this there are four main principles that operate in health care: principle of respect for autonomy; principle of non-maleficence; principle of beneficence, and; the principle of justice. Psychiatric coercion breaches both the principle of respect for autonomy and the principle of non-maleficence, and the justification for doing so is often shrouded in questionable subjective psychiatric jargon and implied authority. An analysis of the subjective feature of psychiatry is required for its part to substantiate the claim that the authority of psychiatry is misplaced and too often harmful. As such, the following section examines human agency to establish whether medical authority and expertise legitimately emerges within the practice of psychiatry.

Human Agency and Authority: The Curse of Expertise

The term ‘expert’ implies the notion of authority, which contains two main senses: ‘expertise’, and ‘the right to rule’. To have authority pertaining to belief (to be ‘an authority’) is to have:

> ...theoretical authority; to have authority over action (to be ‘in authority’) is to have practical authority. Both senses involve the subordination of an individual’s judgment or will to that of another person in a way that is binding, independent of the particular content of what that person says or requires. If a person’s authority is recognized then it is effective or de facto authority; if it is justified then it is de jure authority. The latter is the primary notion, for de jure authority is what de facto authorities claim and what they are believed to have. Authority thus differs from effective power, but also from justified power, which may involve no subordination of judgment. In many cases, however, practical authority is justified only if it is also effective (Green 1998).

In virtue of these two senses and in particular, that practical authority is justified only when effective, the leading question asks: is the authority of psychiatry justified? Expert authority is not just relational to its specific field or practice because in many instances it is mutually inclusive of the exercise of power or influence across several fields such as the authority of expert witness in Courts of Law, Mental Health Tribunals, State Administration Tribunals, for example. The most common problem with the expert-witness, is reliability. By what standards should the term expert be assigned in this context when reliability within psychiatry, is not sustainably established? Disorder as classified in psychiatry is officially biomedical. "Psychiatric disorders and diagnoses are expected to follow the model of … medicine with psychiatric disorders and diagnoses rooted in biomedical pathology" (Phillips, 2015, p. 179). Yet disturbingly, the extent of the model's limitations gives rise to persistent reliability concerns within psychiatry. Reliability is an operational requirement in medicine. Success, in any practice, is often a good measure or criteria as a guide to what constitutes expertise. Over the course of its own life psychiatric success has been far from impressive, for its marred history as measured by patient-maintenance. Psychiatry faces a doubled-edged sword when trying to coherently establish patient-maintenance success that results from nothing more than a placebo effect against success resulting from good clinical management.

Accordingly, in terms of human agency what role does individual-psychology play? Experiments based on decision-making and performance on attention-related tasks, show that the participants can also be influenced by priming and by other external factors as demonstrated by experimenters at Northwestern University (2012). Authors Hajo Adam and Adam Galinsky coined the term "enclothed cognition" to describe the co-occurrence of two factors – "the symbolic meaning of clothes *and* the physical experience of wearing them" (2012, p. 1). The research explored the effects of wearing a lab-coat in one experiment (E1) and in subsequent testing, the coat was referred to as either a doctor's coat (E2), or a painter's coat (E3). The focus of the experiment was on 'attentiveness and carefulness' of the participating subjects. In the experiment, when participants wore the coat called the 'doctor's coat' (E2) the result achieved was an increased sustained attention compared to (E1); and even more so, when compared to participants who wore the lab-coat called a painter's coat (E3) (2012, p. 1). One's belief and attitude towards any task can significantly affect performance and outcome because overall, one's belief, informs behaviour. By analogy, whatever assumed success psychiatry has enjoyed, of that, what percentage is due to placebo effects as rendered from perceived clinical authority? As psychiatrist Allen Frances Chair of DSM-IV Task Force describes:

> Placebo pain pills dampen the brain's response to painful stimuli; placebo antidepressants mimic the brain's effect of real antidepressants; placebo Parkinson's pills stimulate the brain's dopamine system; … placebo caffeine and Ritalin have a stimulating impact on brain centres; and placebo profoundly affect the immune system. … The social factor is also important – being a placebo responder helps maintain key relationships and supports precious communal rituals. ... The medicine

> man and his patients have always shared the need to believe in the healing power of the currently fashionable theories, rituals, chants, incantations, diagnostic and testing procedures, and medicines (Frances, 2013 pp. 98-99).

In other words, the physiological benefit achieved from placebo, though psychosomatic, is quite significant and additional to any psychological benefit. In the following section, research on diagnostic medicine is presented to establish the foundations and development of expertise in medicine in order to provide a comparative analysis with psychiatry as a medical practice.

Diagnostic Medicine

Authors, Geoff Norman, Kevin Eva, Lee Brooks, and Stan Hamstra of *Expertise in Medicine and Surgery* (2006) published in *The Cambridge Handbook of Expertise and Expert Performance,* provide what is still current understanding of the development of expertise:

> Expertise in medicine requires mastery of a diversity of knowledge and skills – motor, cognitive, and interpersonal … Although some specialties such as pathology or surgery may emphasize one kind of skill or another, most clinicians must be skilled in all domains and must also master an enormous knowledge base drawn from areas as diverse as molecular biology, ethics, and psychology (Norman *et.al.* 2006, p. 339).

As a domain of expertise, medicine is unique not only because of the required formal knowledge base, which is extensive, but medicine is also dynamic. Advances in our biological understanding, inclusive of the social and environmental influences, aided by advances in our technologies, render approaches to therapy subject to constant change. With the advent of new drugs and commercial influences, keeping abreast of this continually changing landscape, is a significant hurdle for practitioners. Consider what this means in terms of diagnosis:

> The interplay between the formal knowledge of medicine and experiential knowledge has emerged as a central issue in understanding medical expertise. … Indeed, much of what we call medical expertise is really closer to medical diagnostic expertise, and, of this, much is confined to the diagnosis of problems in internal medicine (Norman et al. 2006, p. 340).

Pointedly, we glean the understanding that medical expertise is closer to medical diagnostic expertise. Norman, et al., (2006) identify three distinguishable yet broad approaches to understanding medical diagnostic expertise as prevalent throughout its history. Earlier understanding predicated on process-oriented studies held that diagnosis was a general skill acquired by practitioners contemporaneously with medical knowledge, "but distinct from knowledge (2006, p. 340). They report a paradigm shift occurred in the 1980's and that the old process-oriented model

was replaced by a new model recognising the central role of knowledge, relative to its extent and organisation. In sum, incorporating a time line to which further investigation found that medical expertise involves coordination among several kinds of knowledge. Thus, three broad types of knowledge were identified and investigated: *causal knowledge* (understanding basic mechanisms and interactions), *analytical knowledge* (formal relation between diagnoses and features – signs/ symptoms/conditions), and *experiential knowledge* (accumulation or experiential-repository of prior cases based on previous experience) (2006, p. 340).

Psychiatry, is largely practice-based and primarily trades on symptom-based diagnosis even though variability among humans is vast, despite the similarity of symptoms co-occurring across disparate and broad range of disorders. So, not without contention, psychiatry's symptom-based experiential method of diagnosis somehow provides the legitimacy it enjoys for its role as a practice. To examine experiential knowledge in this context requires understanding the role of exemplars so pivotal within the domains of mental health and disability healthcare. Experiential knowledge, utilized for diagnostic purposes, is commensurate to recognising suitable exemplars. Psychological examination of the role of prior examples in everyday concept formation is what led to "exemplar theory". In brief, every learned category contains a number of examples acquired through experience. The examples acquired through experience that are to a high extent dependent on experience, are said to be individually retrievable. The sum of these examples provide support for the categorisation of any new cases, based on "some kind of similarity to at least one prior example" (Norman, *et al*. 2006, p. 340).

Exemplar theory shares similarities to *Inference to the Best Explanation* (IBE) which is a form of inductive reasoning employed in abductive arguments derived from C.S. Peirce. Abductive arguments lead to an explanatory hypothesis, as often used in medicine. A typical medical example runs like this: a) patient presents with slight fever and red spots over body; b) an explanation would be patient has measles (hypothesis); c) patient having measles is the best explanation for why there occurs slight fever and red spots over the body; therefore, probably, this patient has measles (Govier, 2010, p. 298). Because measles is a testable disease, makes this line of reasoning quite typical of symptom-based diagnosis. Yet these same symptoms, 'slight fever and red spots' can be confused with other illnesses. Additional complexity obtains with psychiatric disorders, insofar as they are not situated within the same ontological category largely due to an absence of identifiable biomarkers as expected with biological psychiatric disorders that would also provide testable verification of such psychiatric disorders. Whereas in medicine, biomarker studies have increasingly become integral to clinical pharmacologic research for use in producing targeted therapies. Psychiatry, on the other hand, draws blanks on so many psychiatric disorders. For variability between individuals as with variability between presentations of symptoms, loom large. Therefore, where there is great and broad variation among examples and between individuals, the weaker the capacity to diagnose efficiently and reliably (Norman, et al. 2006, p. 341). Other concerns add complexity to establishing reliable and verifiable psychiatric diagnoses.

To examine these, attention turns to assess other measures employed to evaluate and track development to understand the structure of expertise. According to Phillip Ackerman and Margaret Beier, authors of *Methods for Studying the Structure of Expertise: Psychometric Approaches* (2006), we understand psychometrics, as the scientific discipline formed by the combination of psychological inquiry and quantitative measurement. Considering psychometric approaches to expertise the most general revolve around 'measurement and prediction' of individual differences and group differences (e.g. age, gender) and more specifically, to the 'level of proficiency' and 'expert performance' (Ackerman & Beier, 2006, p. 147). These refer more to the acquisition of skills and to the measurement of the individual's development. However, psychometric considerations provide a further approach to the identification of symptoms and equally probable causes of error most linked to 'causal knowledge' and 'analytical knowledge' as described above in the Norman *et al* (2006) research.

To appreciate the pitfalls associated with causal knowledge and analytical knowledge requires apprehending probable factors that when wrongly classified by a practitioner substantially increases the margin of diagnostic error. One such factor of patient diagnostic relevance is that between 'trait' and 'state'. 'Traits' are stable dispositions characterized in two ways: either as 'physical properties', like visual acuity, strength, agility, and so on, or as 'psychological properties', like rationality, and intelligence. 'States', conversely, are characterised as short-lasting qualities distinguishable by changeable moods, so by definition are broad. For example, being excited or happy, then "sad, or angry, sleepy and the like" (Ackerman & Beier, 2006. P. 147). A state therefore includes anything that induces a mood change, such as, a disruption caused by the ingestion of some causal agent, alcohol for example, more explicitly, psychiatric drugs. Hence, mistaking state for trait is a problem associated with both causal knowledge and poor analytical knowledge, as defined by Norman, et al. (2006). The implications are dire. An example of a medication-induced state causing delirium, or psychosis and violent behaviour, is medication-induced akathisia (Greek meaning: 'can't sit down'). "Akathisia is a dangerous adverse effect of antidepressants, antipsychotics and some other drugs that cross the blood-brain barrier" (Eikelenboom-Schieveld, Lucire and Fogleman, 2016, p. 65). Prescribed medicines can increase blood levels "towards toxicity because of genetically determined metabolizing capacities, high doses and interactions with co-prescribed CYP450 inhibitors and synergies" that often-times produce erratic and disruptive behaviour. Pharmacogenetics includes the "genetics of the cytochrome P450 (CYP450) system which are the otherwise invisible factor that can correlate with catastrophic behavioural disturbances" (Eikelenboom-Schieveld, Lucire and Fogleman, 2016, p. 65; Breggin, 2013, pp. 40-41). Severe akathisia-related effects causing violence and suicidality will "abate when medication is decreased, changed or slowly stopped. Suicidality and violence tend to get worse if the dose is not tapered slowly" (Eikelenboom-Schieveld, Lucire and Fogleman, 2016, p. 65; Lucire, & Crotty, 2011; Breggin, 2013, p. 41).

The evidence is both genetically and behaviourally clear (Moncrieff 2008;

Bentall 2010) yet many psychiatrists deny psychotropic drugs produce adverse effects. Much worse, too many psychiatrists are even convinced that "it is not an adverse effect of the drug but a positive sign that the drug starts working" (Bielefeldt, Danborg, and Gøtzsche, 2016, p. 385). Cognitive scientists refer to this style of thinking as 'strategic ignorance': "deliberately avoiding or adapting new knowledge or techniques, strategies, in order to avoid discomfort and to increase our productivity" (Robson, 2019, p. 267). If this is the case, then it is a functional approach and trades on 'motivated reasoning' which incorporates several forms of bias whereby exposure to counterarguments tend to backfire, such that people not only reject the counterargument but that their views, as a result, become more engrained (Robson, 2019). What makes this picture worse is that this same attitude pervades general practitioners (GP's) who prescribe psychiatric medication but due to the lack of appropriate education about the adverse effects of psychotropic drugs, only adds to the crisis. Among psychiatrists and GP's, there is an evident lack in both ethical and clinical recognition that "the CYP450 enzymes can be induced or inhibited by many drugs and substances resulting in drug interactions in which one drug enhances the toxicity or reduces the therapeutic effect of another drug" (Le, 2016, p. 1). The liver's capacity for metabolism through the CYP450 enzyme system with age "is reduced by ≥ 30% because hepatic volume and blood flow are decreased" (Le, 2016, p. 1).

Consequently, over time maintaining or stabilizing a patient with treatment that is supposedly recovery oriented is virtually impossible, particularly when the psychiatrist's reliance is to an ill-guided option that very often turns out to be an unsuitable patient-drug treatment. It follows that due to the misplaced authority afforded psychiatry such to subjugate the autonomy of a patient stands even more pertinent in the overall scheme of medical treatment, not just because they are authorized to prescribe psychoactive drugs, but because it is tantamount to violating a person's autonomy and human rights when the treatment is coerced, enforced, and too often harmful. Remembering, psychiatrists can enforce the Mental Health Act, GP's cannot!

Psychometric approaches to the inquiry of expertise formalize other predictors and one that has some merit in other disciplines regarding reliability, which is relevant to this study of psychiatric expertise, is 'inter-observer reliability'. Broadly, this refers to an 'index of agreement' between different individuals who act as judges. An application of this method occurs when an individual performance cannot be objectively evaluated (e.g. music composition, gymnastic tournament, artwork submission, etc.). When agreement between judges in rank-ordering of individuals is high that corresponds to high inter-observer reliability; where there is "little agreement, reliability of the judgements is low" (Ackerman & Beier, 2006, p. 148). The problem, however, encountered in mental health and disability sectors is reliability and verification of diagnosis (Zachar & Jablensky, 2015). This kind of modelling when used in case conferences, for example, between groups of psychiatrists, even if inadvertently, often incorporates biases perpetuating misunderstood patient symptoms and the consequent errant diagnoses. Hence, a significant indication of internal problems for psychiatry as a profession relates to

misdiagnoses involving mistaking 'state' for 'trait'. By misdiagnosing symptoms, for example, mistaking tardive dyskinesia for catatonia (Zachar & Jablensky, 2015, p. 8); or akathisia for hyperactivity; or exuberance for attention deficit disorder; or unhappiness and boredom for depression; trauma for a whole range of so-called psychiatric disorders, etc.; these errors, will ultimately lead to mismanagement and inappropriate treatment options (Whitaker, 2015, p. 212; Kolk, 2014, pp. 37-38). This is a common occurrence and not an exception to the rule of psychiatric practice. The current dominant psychiatric drug-based paradigm of treatment progresses through a trial and error prescriptive process of readily changing medication in exploratory practice to find a suitable assumed medication-to-client fit, too often at great cost and adverse harm to child/patient/client (Steingard, 2019, p.116). Rather disturbingly, even though verifiable and reliable scientific methods are available through pharmacogenetics, as mentioned above.

Furthermore, misdiagnoses involving psychiatrists mistaking 'state' for 'trait' generates additional repercussions that impact patient welfare rather significantly, that of which involves the under-reporting of adverse events. It is estimated that only about five-percent of adverse events are reported by practitioners, nationally. The Minister for Health the Hon. Greg Hunt in a letter dated 20 August 2018 to the Chair, Standing Committee on Petitions, acknowledged that under-reporting of adverse events is a global issue (author sighted letter). Likewise, Robertson and Newby (2013) in *Low Awareness of Adverse Drug Reaction Reporting Systems: a consumer survey*, identify a massive gap in psychiatric drug related adverse effects being reported. Most often consumers report adverse-effects to their prescribing psychiatrist yet all too often the adverse effects are rationalized away by the psychiatrist. More broadly, relying on the prescribing practitioners to report such adverse events is evidently a very poor and unreliable pathway to register such adverse drug-events. Indeed, interrogating why there are such low numbers of reported adverse events, can arguably be understood as a conceptual and attitudinal issue about how psychiatrists, in particular, play down adverse effects and quite commonly define them as comorbidities (Breggin, 2013; Davies, 2013; Hari, 2018; Kolk, 2014; Steingard, 2019; Whitaker, 2015). Unfortunately, many patients are subsequently prescribed additional medication by their psychiatrists (problem of polypharmacy), to treat the adverse-effect or insist the patient requires Electro-Convulsive-Therapy (ECT) (Moore, 2018) when otherwise, as is not uncommon, the psychiatrist characterizes the patient as 'medication resistant' (Breggin 2013; Davies 2013; Gøtzsche 2013; Moncrieff, 2008; Steingard, 2019).

The chief error in psychiatry is overstatement and though its aim is plausible its success exaggerated. This, in effect on a grand scale, is to commit the 'fallacy of misplaced concreteness' as coined by Alfred North Whitehead (1978, p.7):

> This fallacy consists in neglecting the degree of abstractness involved when an actual entity is considered merely so far as it exemplifies certain categories of thought. There are aspects of actualities which are simply ignored so long as we restrict thought to these categories.

Mistaking adverse effects for comorbidities, misdiagnosing trauma for mental disorders to say the least about the practice of psychiatry is to recognise the fatal error so often committed by psychiatrists, is the 'fallacy of misplaced concreteness'.

To further establish the need to rethink the authority wielded by psychiatrists the following section draws upon the literature on biological psychiatry and comparative practices to highlight the significant deficits bedeviling psychiatry in general.

Psychiatry: Verifiable Biomarkers, Rare Findings

Problems associated with psychiatric disorders, as indicated above, emerge from a paucity of identifiable 'biomarkers' that would otherwise provide verification and diagnostic reliability for the many disorders described by psychiatry as defined within its five iterations of the Diagnostic Statistical Manual (DSM). A biological marker aka "biomarker", refers to a medical sign, specifically, objective indication of medical states. Importantly, biomarkers are indicators used to achieve reliable prediction that can be 'measured accurately and reproducibly' (Strimbu, & Tavel, 2010). Their utility serves clinicians and researchers in multiple ways from making and evaluating clinical decisions and subsequent treatment assessments in addition to furnishing measurement purposes, such as disease tracking and response, to serving diagnostic and prognostic determinations.

Psychiatry, as a clinical practice, faces fundamental problems, two of which are: firstly, it cannot rely on identifiable biomarkers since they are largely nonexistent across many psychiatric disorders, and secondly, concern over diagnostic irregularities (Davies, 2013; Frances, 2013; Zachar, et.al, 2015). Two missing necessary conditions for expertise and medical authority, giving reason to question psychiatry as a domain of expert practice, let alone, mental health specialists. Rather perniciously, some might say, psychiatrists, by and large are not effectively taught how to taper medication. What should constitute medical professional education therefore is largely inadequate and given its history, this is a gross oversight in terms of formal clinical education psychiatrists receive. It also raises a whole series of ethical questions related to professional integrity, responsibility, duty of care to minimise harm under the principle of non-maleficence and indeed accountability when harm, due to poor clinical management, is inflicted.

Psychiatry: Requirements and Consequences

Adding weight to this discussion is psychiatrist Bessel Van der Kolk whose life-long work, published under the title *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma* (2014) provides evidence grounded in empirical longitudinal studies. The work includes the presentation of studies conducted in several treatment centres across the globe drawn from a range of health and social disciplines. The increasing understanding of trauma, situates it, as

one of the most serious public health concerns and its manifestation and effect rather extensive. Kolk is critical of standard approaches to trauma and extended problems dealt with by practitioners, even those within his own field. Kolk argues that too many psychiatrists and other clinicians fail to recognise the symptoms of trauma, and as a consequence misdiagnose, then mismanage their patients, however inadvertently, in effect aiding the generation of comorbidities.

Kolk's work was inspired by Stephen Porges' foundational development of the Polyvagal Theory that emerged from the "study of the evolution of the vertebrate autonomic nervous system (Porges, 2011, p. 263). One main insight drawn from the theory is that many of our social behaviours and vulnerabilities to emotional disorders are "hard wired" into our nervous system" (Porges, 2011, p. 263). The theory provides ways of thinking about certain aspects of mental health, to develop 'treatment techniques' that enable people greater means of communicating and 'relating better to others'. The referent for the term polyvagal is the vagus nerve ('poly' means 'many' and 'vagal' points to the vagus nerve). The vagus nerve is an integral component of the Autonomic Nervous System (ANS). The vagus nerve extends from the brainstem to its interconnected branches to regulate several organs, not least the heart. According to the theory, there are two branches of the vagus that "are related to different behavioral strategies, one related to social interactions in safe environments and the other related to adaptive responses to life threat" (Porges, 2011, p. 263).

The historical understanding of the ANS interprets two opposing components, one the sympathetic and the other parasympathetic. This understanding, dates back to the 1800's and took the form of an antagonism model. As Porges' explains, the model characterised the function of the ANS as a continuous battle between the two components. On one side, the sympathetic nervous system taken to be associated with fight-or-flight behavioural responses and the other side, the parasympathetic nervous system taken to be associated with 'growth, health, and restoration'. Since most of the organs of the body, for example, the heart, the lungs, and the gut, have "innervations from both sympathetic and parasympathetic components, the paired antagonism model evolved into "balance theories"" (Porges, 2011, p. 264). What Porges describes is very significant and testament to the paucity of understanding in which several medical schools of thought, including psychiatry, reliant upon an understanding of physiology fall behind, not keeping pace with new developments:

> Balance theories attempted to link tonic imbalances to both physical and mental health. For example, a sympathetic dominance might be related to symptoms of anxiety, hyperactivity, or impulsivity, while a parasympathetic dominance might be related to symptoms of depression or lethargy. In addition to the tonic features of autonomic state, the paired-antagonism model also assumed to explain the reactive features of the autonomic nervous system. This dependence on the construct of "autonomic balance" is still prevalent in textbooks, although there has been an intervening century in which neurophysiology has documented a second vagal pathway involved in regulating autonomic function. Unfortunately, this new knowledge of the second vagal pathway has not permeated the teaching of physiology,

> which still is dominated by descriptions of the paired antagonism between the sympathetic and parasympathetic components of the autonomic nervous system (Porges, 2011, p. 264).

This failure to keep pace with the emerging and new knowledge of physiology is what allows the myth of 'chemical imbalance' to persist. The myth of chemical imbalance that forms part of the narrative emanating from the ranks of pharmaceutical industry-influenced research and their spokespersons, is what otherwise is meant to be the source underpinning mental health problems (Bentall, 2010; Davies, 2013; Moncrieff, 2008; Pies, 2019; Whitaker, 2015). As psychiatrist Ronald, W. Pies (2019) laments: "The fact is, there could never have been a scientifically based, chemical imbalance theory of mental illness, because a genuine theory requires an integrated network of well-supported, interlinked hypotheses". It is not that people do not experience some kinds of imbalance at times but not exploring the causes (nutrition, stress, chemical assaults on our brains, vitamin deficiencies, maturation, stress, trauma, etc.) and distorting the diagnosis such that consumers are led to believe that the only cure is through psychiatric drugs, is arguably unethical. Compliance towards professional practice requires duty of care and due diligence to keep abreast of up to date knowledge of one's clinical practice, particularly so on the part of the prescribing psychiatrist, when the drugs administered to patients can be, and are, very dangerous. The clinical literature on the dangers of psychiatric drugs is vast, and ignorance is no excuse. Accordingly, in practice, knowingly administering medication that produces debilitating adverse effects greater than the intended benefit for recipients from medications/drugs, is negligent and is a breach of the professional and ethical principle of Non-Maleficence or 'Do No Harm' to say the least. Current psychiatric practice exposes a fundamental lack of analytical thinking and reflection in practice on the part of its practitioners and this suggests that the education psychiatrists receive is drastically deficient and in effect, and in no small way, compromises the safety and well-being of many patients/consumers. A revolution in psychiatric training is required and greater accountability assigned to its practitioners under the principle of justice, given the influence they exercise in the construction of Public Health Policies.

In this essay I argued that the misplaced authority of psychiatry is harmful. The criteria required to justify and satisfy psychiatric expertise is not sufficiently established as substantiated by compelling reason to rethink its authority as a reliable profession. The identified criteria required to substantiate psychiatric expertise were found to be deficient. The main concerns dealt with related to diagnostic problems – reliability and verification of diagnoses and testable validity of diagnoses. In part due to the absence of underlying biomarkers ordinarily related to disease or biological conditions that psychiatry continues to face, verification, reliability and validity of diagnoses problems. In addition, a problem psychiatrist's face is distinguishing between reactive-depression and endogenous-depression; with that the general problem of reliably distinguishing between conditions constitutive of 'trait' and that of 'state' (e.g. reactive depression;

adverse-effects from medication, etc.). Psychiatrists underplay the significance of the placebo effect which is linked to concerns regarding appropriate treatment and prescribed dosages. Considerable concern is directed at the persistent under-reporting of adverse effects which is a disturbing omission of responsibility in psychiatric health care. Disconcertingly, practitioners instead regard and treat adverse effects as comorbidities, consequently, involving polypharmacy and thus amplifying dangerous adverse effects, in particular, suicidality.

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