Is Psychiatry Ethical?

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The author considers the practice of psychiatry in Ireland in the context of mental health distress. He looks at some historic controversies related to lobotomy and in Ireland the use of electroconvulsive therapy (ECT) which is still practiced in Ireland. He also looks at the contemporary context in the Irish mental health services. He offers a critique of psychiatry believing it to be in the service of a scientific status quo and its own power base rather than applying up to date science in the primary interest of the client. He outlines criticisms of the DSM 5 including those from the field of psychology. He also discusses the impact of medication for restraint and control which he claims is also responsible for shortening the lives of patients. Then he discusses the move in research focus to the Research Domain Criteria of the US National Institute of Mental Health and considers what this might mean for psychiatry. He explores the recent refusal of the Irish government to formalise in law the participation of families in the care those in psychiatric care. He concludes by asking if psychiatry is ethical.

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In this article I will refer to content of a recent radio documentary broadcast in Ireland. I will use this to consider some historical and contemporary controversies associated with psychiatry. In discussing psychiatry I will outline the example of Freeman who developed the lobotomy and, related to this, the contemporary use of Electroconvulsive Therapy (ECT) in Ireland. Some of the literature related to ECT efficacy will be discussed. I will then discuss my experience of psychiatry as a psychotherapist and the rigidities that seem to me apparent in the reactions to challenges raised when discussing client presentations. In discussing the power of psychiatry I will explore the position of psychiatry vis a vis the state and the critique of psychiatry as complying with cultural and political demands. Connected to this reference will be made to the high level of institutional incarceration in Ireland during the 1950s ostensibly for mental illness, a rate of imprisonment which at one time was the highest per capita in the world. I will discuss what I perceive as the death of the DSM and the growing criticisms of DSM including from psychology. I will explore the refocussing of mental health research by the National Institute of Mental Health to its Research Domain Criteria, which is an attempt to restart mental illness research from first principals while incorporating a more continuum-based approach to human mental distress. I will briefly discuss the emerging research which exposes the adverse effect of psychotropic medication on the life expectancy of those with mental distress. I will then discuss some controversial diagnoses included in historical and contemporary versions of the DSM. I will review a recent refusal of the Irish government to facilitate more family involvement in psychiatric care. Finally I will ask whether, given the expediency, controversies and issues that allow us to critique psychiatry, if the practice of psychiatry is ethical.

An excellent documentary by an Irish radio channel, Newstalk 106 (McCrea 2015), about the history of lobotomy was recently broadcast. The technique of lobotomy was originally created by Moniz, a Portuguese neurologist who won a controversial Nobel Prize in the late 1940s. One of the surviving subjects of the procedure, Howard Dully, was interviewed as a grown man for the radio documentary. He was 12 years old when he was lobotomised by the infamous American psychiatrist Freeman, who developed Moniz' procedure, which was vividly described by the programme as being carried out with a "flick of the wrist". Freeman had discovered an inventive, more direct and straightforward route to the brain via the eye socket using what was effectively an ice pick. As a boy Luddy recounts his stepmother bringing him to a number of doctors, most of whom declared nothing to be wrong with him (Norris 2005). That was until he was introduced to Freeman who had finessed the lobotomy procedure into a ten minute brain scrambling exercise. Freeman took on the case with gusto, not telling the boy what was to be done.

The Newstalk documentary also spoke about the use of a form of ECT in support of Freeman's procedure. The use of ECT continues controversially to this day and is still used extensively, as I would describe it, in Ireland. A 2011 position paper from the College of Psychiatry of Ireland supports the continuing, considered use of ECT, claiming that the use of ECT is rare. Though given that Freeman carried out a total of 2,500 lobotomy procedures during his whole career (and though it is not the same procedure at all, it may share many of the underlying clinical contexts that gave rise to lobotomy operations), ECT is used on 450 people per year in Ireland which in my mind could hardly be said to be rare, as claimed by the above paper.

A 2010 literature review by Read and Bentall focuses on the use of ECT for depression in particular. They conclude that "the cost benefit analysis for ECT is so poor that its use cannot be scientifically justified". Earlier, some years ago, a similar conclusion had been reached in relation to the use of lobotomy which had been subject to criticism for some time before it was stopped by the Soviet Union and subsequently by other countries. As the poor efficacy of Freeman's procedure began to emerge, the credibility of his lobotomy procedure in particular, and by extension brain surgery for mental illness in general, received such a blow that a bias against these kind of brain operations persists to this day.

In my view it is wrong that the practice of ECT continues. By way of example around 50% of those "successfully" treated with ECT for major depressive disorder relapse, often related to a refusal to adhere to medication regimes (Huuhka et al. 2012). ECT seems to me to be an institutional convenience for difficult patients rather than an effective medical treatment. It is therefore a kind of restraint rather than a healing intervention and as such is an expedience rather than a primarily healing treatment. For me the use of ECT is an issue of ethics and individual agency, in addition to the scientific fact that its use is not scientifically supported. If you are zapping someone's brain with electrical current you are in part robbing them of their full agency. Continued use of ECT with the support of psychiatry in Ireland demonstrates the danger and persistence of poor science dressed up in a white coat as best practice. No doubt individual reviewers, writers and practitioners are well intentioned in their actions. I predict and hope that ECT will be consigned to the history books along with lobotomy within the next 20 years, if not before then.

As a medical specialty, now and historically, psychiatry is recognised by critical writers as acceding to the demands of the state in order to comply with cultural and political demands,

while publicly occupying the scientific high ground. Psychiatry and the weakened it supposedly treats often confuse its power status with a superior morality and manifest a zealous righteousness when it comes to patient care. As the Newstalk documentary reminds us Ireland once had the highest rate of mental illness incarceration per capita in the world. Presumably this statistic was achieved with the complicity of psychiatry. I am not aware that psychiatry has publicly acknowledged its part in this atrocity. It should do so and it should apologise.

As someone who is trained to listen to rigidity in the speech of clients it always amazes me to hear the institutional rigidities encountered in the dialogue of highly educated adherents to the medical model, as they aggressively respond to my occasional challenges to their knowing perspectives about mutual clients. Any challenge to such rigidities by a psychotherapist such as me is often met with a contemptuous dismissal and no further discussion. In Ireland, those of us who are trained outside the medical model to begin our work from where the client stands do not have much power. Those psychiatrists who stand in defence of status quo science, even where this contradicts the client's reasonably expressed preferences and more up to date science, have been given all the power that the state can muster up to the point of physical restraint. Thankfully, increasingly, there is a new breed of more liberal and enlightened psychiatrist emerging. This is also mirrored in a growing user movement that is increasingly critical of psychiatric practices.

This may or not be in time to rescue psychiatry from the adverse impact of the highly criticised DSM 5 (Kecmanovic 2013 for example). This latest incarnation of the diagnostic bible of psychiatry has been attacked by the previously compliant and supportive psychology perspective. The British Psychological Society (2011) was moved to criticise DSM 5 "for being based on social norms and subjective judgement, and for locating problems within individuals rather than recognising the role of social causes, such as poverty." I would guess that if the DSM can no longer rely on social norms, subjective judgement and spurious science it might be a very slim tome indeed.

Psychiatry knows, but has not yet acknowledged, that the DSM in its current form is dying a slow death. The US National Institute of Mental Health (NIMH) has introduced a project called the Research Domain Criteria (RDoC) to effectively rewrite our understanding of mental disorder, separate to the DSM process. RDoC is using environmental and neurodevelopmental constructs to fill a matrix of research findings in order to understand mental distress more effectively. The idea is to create a basic understanding of the issues involved through primarily scientific research, including research that may also include self-reporting. It would seem that the NIMH has rejected the science by clinical observation and committee that seems to mark the DSM approach to mental illness (Davies 2013) and is acknowledging the continuum of human experience rather than the historically categorical insistence of the DSM approach. The focusing of resources away from the DSM to the first principal mental health research being undertaken by the RDoC project is not so much a nail in the coffin of DSM-based psychiatry but represents a basic construction of the coffin itself. There remains quite a few nails, however, before the latest manifestation of the perversity of psychiatry (the DSM 5) is dead and buried. Psychiatry will desperately hold on to its power with grim determination even as the basis for its current power base erodes and passes into history. I do not believe that psychiatry is any danger of disappearing, however it will have to evolve to accommodate the demands of its critics and its users.

In truth what sufferers of severe depression need is not spurious diagnoses based on poor science or institutional othering but long-term, patient and compassionate support, perhaps enhanced by voluntary medication, but certainly not via the unscientific use of ECT or the long term, debilitating use of chemical restraints. It has emerged how some psychotropic medications, used ostensibly to support those with mental illnesses and the concept of care in the community, a misnomer in my experience, is also killing off sufferers considerably more quickly than the general population. It seems that not only is psychiatry controlling those with mental distress, it is also killing them off early. Davies (2013) also points out the relatively large portion of pharmaceutical funding directed towards psychiatrists compared to other doctors, some 50% of all medicine funding (Groeger et al. 2015).

Critical writers have described psychiatry as a tool of social containment. Homosexuality as we know was at one time considered a mental disorder. In the current incarnation of DSM bereavement may well be diagnosed as a mental disorder. There is also a condition called Premenstrual Dysphoric Disorder. This is now a mental disorder, remember, not merely a severe manifestation of a very real phenomenon. DSM 5 is saying you have a mental disorder if you suffer from this condition. The most prevalent symptom of this condition is irritability (Htay and Aung n.d.). Ergo if you are a woman who is very irritable during menses you are disordered from a psychiatric perspective. In theory, admittedly in extremis, during your next period you could be locked away in a hospital for the mentally ill. How many "irritable" women and wives were locked up in the 50s in Ireland by husbands, fathers, brothers, doctors and psychiatrists?

The Irish government has recently declined to provide a more defined legal basis for the participation of families in the care of psychiatric patients (English 2015) even where family members or offspring may be at risk. In addition to this crucial element of risk to those close to them, families often know more about the care needs of their children, siblings or partners than the psychiatrists who have most power over the actual treatment of psychiatric patients. In Irish law most of the power in relation to the treatment of more severe mental distress remains with the psychiatrist or his/her colleagues and there is little formal recognition of the family's rights to participate. Also, it appears that health care professionals in Ireland are often working with paper based filing systems which may not contain complete clinical histories where previously patients have been treated elsewhere. To put it mildly, all of this is not bode well for a psychiatric patient.

It is clear from all of this and from my professional experience of psychiatry that although it is trying to do its best, it often seems to be working more in the service of the state and the administration of medical and physical restraint, in a historical context of the lack of priority given to mental distress in Ireland. As a group psychiatrists must also be interested in retaining the power that the law delegates to psychiatry. Psychiatry appears more willing to administer chemical and physical constraints in this context, with the encouragement of the looming pharmaceutical giants, than to protest at the appalling level of support that has been given to those in Ireland who receive psychiatric diagnoses.

In considering mental health policy in Ireland I am reminded of the Irish joke, "If I was going there, I wouldn't start here." By this I mean psychiatry seems to me to have compromised its ethic as a result of its enmeshment in the service of the state to such an extent that the care of the patient, while still a priority, is hampered by scientific and power shibboleths that psychiatry is reluctant to let go of. Over time its accretion of power within the mental health

arena, in return for its compliance with this sorry state of affairs, has eroded its ethical connection with *primum non nocere*. Given all of the issues referred to above and other of the many documented historical injustices visited upon us since its inception, for me the question for the practice of psychiatry is: "Your profession is merely expedient, is it ethical?"

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