

# THE MADNESS OF OUR MENTAL HEALTH SYSTEM: TURNING COMMON HUMAN EXPERIENCE INTO ILLNESS

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*Imagine telling a story, mostly fictional but with a sprinkling of facts, so plausible and compelling as to be taken as true and internalised by whole societies – societies proud of their pre-eminent science and enlightenment; a story adopted and championed even by professionals, academics and major societal institutions – including governments; a story in which millions of citizens are deemed to suffer from psychological conditions termed in the story, ‘mental illnesses’, which must, at the cost of billions of dollars, be medically diagnosed and remediated by doctors, mental illness professionals, and drugs of questionable safety and even more questionable efficacy.*

Well, as it turns out, this happens to describe the origin and reality of our present mental health system, beginning with a largely pseudo-scientific narrative followed by and necessitating a chain of responses and expenditures. This narrative and its resultant system, have become the predominant and accepted response of Western societies to the distress and difficulties of common human experience; both narrative and system have been owned by medicine and health institutions as the preferred approach to ‘mental health’, and have been afforded the status and legitimacy of evidence-based science, purporting to benefit human psychological health and wellbeing.

This article explains why we should be deeply disturbed by this largely fictional narrative and its resultant system; why we should be suspicious of who actually benefits from the whole enterprise; why it is a largely unnecessary burdensome cost to our economy, and, most importantly, why we can no longer countenance the unconscionable toll it takes on the psychological health and wellbeing of ordinary citizens.

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## The ‘pandemic’ we didn’t need to have

The number of people in our community now being diagnosed with and medicated for a mental illness or disorder, poses a major challenge for our already overburdened mental health services and the funding required to sustain them. Depression and anxiety (the predominant and highest prevalence diagnoses) have apparently reached record levels. We are told by the mass media and our major mental

health institutions that these are one of the major health challenges of our generation. The question is: what is so badly amiss with Western society that should occasion such an historically unprecedented decline in people's psychological wellbeing? One must begin to wonder why humanity has suddenly taken such a turn for the worse. Clearly, the psychiatric/medical remedy applied to this problem is a failed enterprise, with the reported prevalence of 'mental illness' being unremitting in its escalation, with Australia, Britain and the US reporting between 18 – 25% of their populations now afflicted with a mental disorder.<sup>1,2</sup>

Are we really succumbing to a pandemic of mental illness, or is there another explanation for what is happening? Well, what so many ordinary citizens (non-mental health professionals) have suspected for some time, actually goes right to the heart of the matter: that perhaps there is a problem with the way we have come to define and respond to personal distress – including psychological and emotional difficulties, which previously would not have been the domain of medical intervention and diagnosis, and would have been largely resolved with various forms of non-medical human support. Augmenting this idea with some closer analysis of the mental health 'industry', what we discover, contrary to what we have been told so often, is not a crisis of mental ill-health at all, but the effects of a deeply flawed narrative of 'mental illness', directly related to *the systematic medicalisation of common human experience*. Put simply, a whole gamut of common, albeit sometimes very challenging and disconcerting human experience, has been corralled by *medicine* (and in particular its specialty of psychiatry) and referred to as illness; and where there is illness, treatments and especially drugs are utilised to attempt to cure it. Had this been a sudden event or decision of governments it might have been seriously questioned, but unfortunately, it is a phenomenon which has crept up on Western societies over recent decades. To use the words of poet Francis de Quevedo, it is one where: *not only are things not what they seem, they are not even what they are called*.

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## **How medicine loses its way when it comes to mental health difficulties**

The endeavour of detecting, understanding, diagnosing and treating physical illness is the hallmark paradigm of modern medicine, and one that has shown itself in many ways to be of remarkable merit. However, this approach though persistently applied to psychological difficulties (or 'mental illnesses' and 'disorders', as they have been termed), has shown itself at best to have quite limited benefits. When applied to the highly complex individuality of psychological experience, which reflects a changeable interplay of mind, emotions, behaviour, physical sensations, and factors of social and physical environments, it quickly finds itself out of its depth. Attempting to shoehorn this dynamic complexity into static psychopathological illness categories, it is forced to depart from science into untenable reductionism; some would go as far as to say, pseudoscience. This tendency of reductionism expresses itself in another disturbing way: when medicine views an individual mostly as an organism – to which a diagnosis and treatment is applied, rather than a person of unique complexity, who is also a self-acting agent, living in a demanding world and environment which impact on and are integral to their daily life.

How doctors and mental health professionals choose to view (or 'frame') the person in front of them determines what they ask, what they see, and suggests their options for responding. As Psychiatrist, R. D. Laing (well known for his critical analysis of conventional psychiatry) emphasised, our relationship to an organism is different to our relationship to a person. How we view and respond to an organism compared to a person, reveals different aspects of reality and a very different set of information.<sup>3</sup>

No person exists or experiences, apart from his or her world and others with whom they relate. Consequently, we can never dispense with context or wider determining factors as if they are appendices of questionable value, or a mere curiosity in the enterprise of responding to mental health difficulty. When a person seeks out a doctor or a therapist

because they are in distress or are encountering a mental health difficulty, they do so with a known sense of their personal history, their whole *being-in-the-world*, and that every aspect of this is interrelated in some way.<sup>3</sup>

There is a common illusion that we somehow increase our understanding of a person if we can translate a personal understanding of him or her into the impersonal terms of an organism or system comprising of a sequence of processes. This is an erroneous perspective. The medical approach is inadequate in dealing with the person in this regard and exhibits an inveterate tendency to depersonalise them and render a reductionist account of them: an isolated set of symptoms to be treated, rather than seeing them as a resourceful self-acting agent.<sup>3</sup>

Interestingly, empirical *trans-theoretical common factors research*, which aimed to identify key contributors to positive and effective outcomes in psychotherapy, discovered that extra-therapeutic variables (a person's own personal, interpersonal, and environmental capacities) contribute a huge 40% to these outcomes, with therapeutic rapport coming in second at 30%, and therapeutic method and placebo each being last, individually contributing 15%.<sup>4,5</sup>

This all begs the question: how did we ever arrive at the point at which we now find ourselves in a mental health enterprise that seeks to remedy the broad complexity of human distress merely with medication and therapy methods, when neither are usually what are most beneficial?

### Why mental illness labelling is depressing

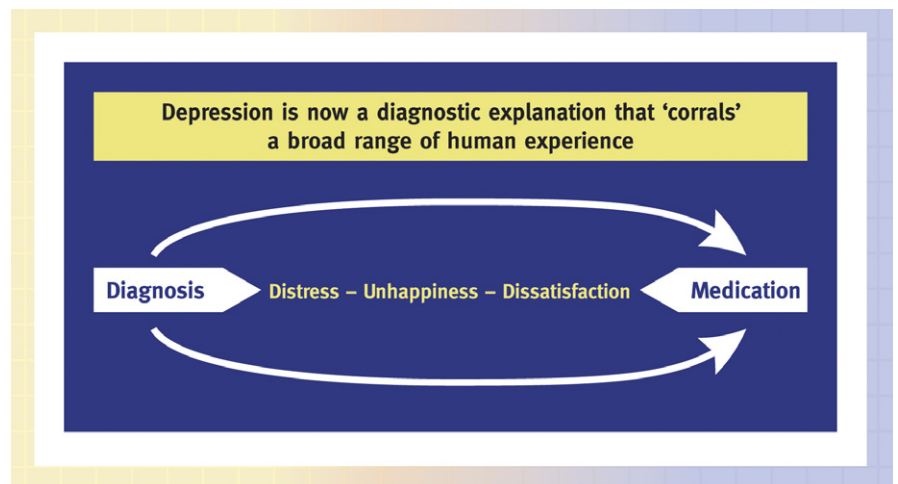
For a prime example to illustrate the problem of turning common human experience into illness, one need look no further than that of depression, which has been deemed by the 'mental health' commentariat to be an 'epidemic' and a 'serious social issue'. Major or intense depression can certainly be profoundly challenging and debilitating. The problem is, depression is now a diagnostic explanation applied

to a broad range of human distress that does not warrant an illness diagnosis or medication in most cases, even though it might be sufficiently intense to warrant referral for counselling or psychological support. Nevertheless, depression has been popularised in such a way as to dominate contemporary thinking about the experience of distress, unhappiness, and dissatisfaction.<sup>6</sup>

Depression is now diagnosed with greater frequency than throughout most of the twentieth century: its 'prevalence' has attracted an enormous cost associated with its 'cure', being the main condition for which anti-depressant medication is prescribed.<sup>7,8</sup> In Australia, antidepressant utilisation nearly trebled between 1990 and 1998, and has continued to increase.<sup>9,10,11</sup> It is interesting to note that, of OECD nations, Australia is currently the second-highest prescriber of antidepressant drugs.<sup>12</sup> Vastly more people are now being diagnosed with depression, and prescribed antidepressants, than several decades ago. Again, these developments have profound social, economic, and public health implications.

### Does depression have an adaptive purpose?


If the answer to this question happens to be yes, what do we gain for a person by merely medicating them? Some emotions can create an intense state of self-absorption; we can become fused to our experience, so that all we can think to do is escape it or sublimate it somehow. Unfortunately, avoidance may only perpetuate the experience and will likely intensify it.



According to Psychiatrist Carl Jung (a contemporary of Sigmund Freud) depression is a compelling voice urging us, not to run away, or to cover over, but to bring content of our unconscious into consciousness, that is: bringing what is sitting at the back of our minds muddying our emotions and diminishing our outward-bound energy, into consciousness. Depression intentionally narrows our attention, and curbs our ability to engage in pleasure sublimation, in order to get our attention.

We are being summoned to engage with and integrate more effectively, past memories and experience, and to bring into perspective ideas and beliefs that may be self-limiting.<sup>13</sup>

Jung believed that depression foreshadows a potential renewal of personality or the readiness of a new page to be turned. How does it help to medicate a person in a way that merely dulls their senses and little else? To do so can be a form of collusion with avoidance, ensuring a worsening condition rather than remediation of one.



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Depression means literally 'being forced downwards', Jung would say, because we have become cut off from some things of importance within ourselves; and of course, what people often need to confront are their own corrosive, emotionally and physiologically debilitating fears.<sup>13</sup> It has been said that, if we do not exercise the power we have, it will slip imperceptibly into the hands of others; in can also fall into the 'hands' of our worst fears, which are then empowered to tyrannise us.

Jung suggested engaging with our experience of depression, learning from it not getting rid of it: thus, freeing us from the impossible expectation that things should be easy, that life should be always happy, and that we can just run away from things rather having to listen, learn, and work them through.<sup>13</sup>

## **The psychiatric catalogue that has a disorder to suit almost everyone**

The transformation in the way we have come to understand human experience as 'illness', perhaps gained its greatest momentum with the introduction of the American Psychiatric Association's, *Diagnostic Statistical Manual* (which is now in its 5<sup>th</sup> edition: the DSM V), an attempt to provide psychiatrists and other mental health professionals with a comprehensive catalogue of all 'recognised' mental illnesses and disorders, including their symptoms. Psychiatrists and other mental health professionals dealing with people's mental health difficulties, do need some common language and conceptual basis for collaboration and advancing research. However, medicalising and pathologising much arguably common human experience and behaviour, as the DSM does, not only tends to discredit the psychiatric enterprise, but provides a basis for simplistic and arbitrary diagnoses widespread in primary care, in the mental health services field, and evident in most mental health literacy and mental health promotion initiatives.<sup>14</sup>

Editions of the DSM have always attracted controversy and criticism, including from many psychiatrists and doctors themselves; the most recent version (DSM V) is no exception. Criticisms include: lack of empirical support, a revision process and content influenced by the pharmaceutical industry, and, an irrepressible tendency to medicalise and pathologise human distress – patterns of behaviour, mood, and experience for which a person may well need professional support, yet which do not constitute illness or disorder.

Labelling human distress as 'illness' or 'disorder', is not a mere linguistic trifle, it can have quite negative consequences for patients. As someone once quipped: *labels should be applied to jars not to people*. There is also the ethical issue of science and medicine betraying the trust of consumers (whose trust they cultivate), by allowing it to be thought that the mental illness narrative (informed by the DSM) is actually evidence-based science, when so little of it actually is.<sup>15, 16</sup>

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If we took a snapshot of a significantly difficult time in almost any individual's life, one affecting their emotions, mood, physiology, and behaviour, we would very likely discover that what characterised their experience corresponded with a disorder profile listed in the DSM.<sup>18</sup>

If we took this same snapshot and presented it in a busy General Medical Practice appointment, it would be even more likely to be identified as representing a DSM illness or disorder

because of the lowering of diagnostic thresholds often characteristic of these contexts of consultation, due to so called *'10-minute medicine'* There simply isn't time even within a 20 minute session to adequately listen to, contextualise, or appreciate the complexity of patients' psychological distress or difficulties, let alone offer a useful diagnosis or treatment suggestions.<sup>19</sup>

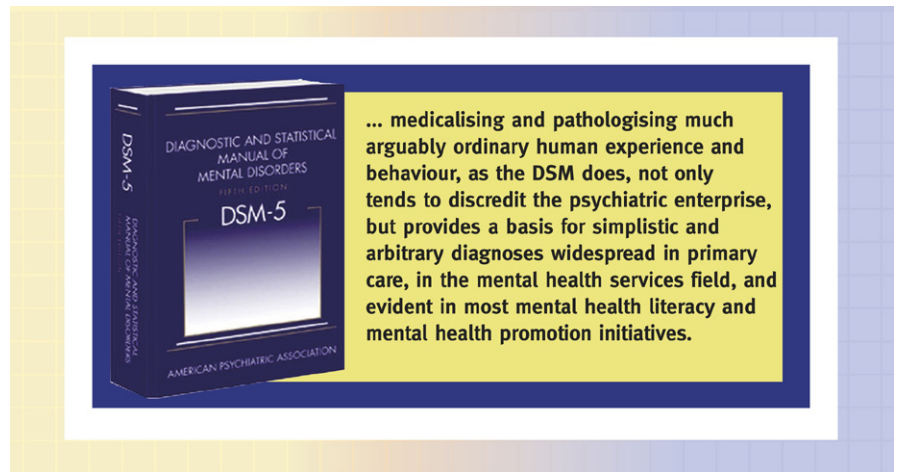
In the United States, a 1993 study by the Rand Corporation showed that over half the physicians wrote prescriptions after discussing depression with patients for three minutes or less.<sup>20</sup>

Whilst many GP's do try and refer patients to psychological services (rather than just prescribing drugs), to be eligible for subsidised services, patients require a diagnosis that fits with the criteria of a recognised disorder or illness. The demand for such services is already overwhelming in many parts of Australia (which means some consumers must wait months for appointments); a dilemma now being targeted by short-term stop gap measures such as online resources and IAPT programs (Improving Access to Psychological Therapies), which are themselves problematic, and simply perpetuating an ailing model of mental health care.

### **Not medicalising common human experience actually encourages taking it more seriously**

It is important that we are not seen here to in any way to be trivialising the human suffering caused by psychological distress or mental health difficulties; in fact, though it may seem somewhat counterintuitive, our purpose (consonant with what is termed: *The Situational Approach*)\* is to reconceptualise human experience in a way that demands a greater regard for it and more appropriate and helpful supportive responses. And it needs to be said, there are cases of mental health difficulty that do warrant some medical intervention and perhaps the limited and evidence based use of psychotropic medication – such as when people are put at risk or severely depleted in capacity because

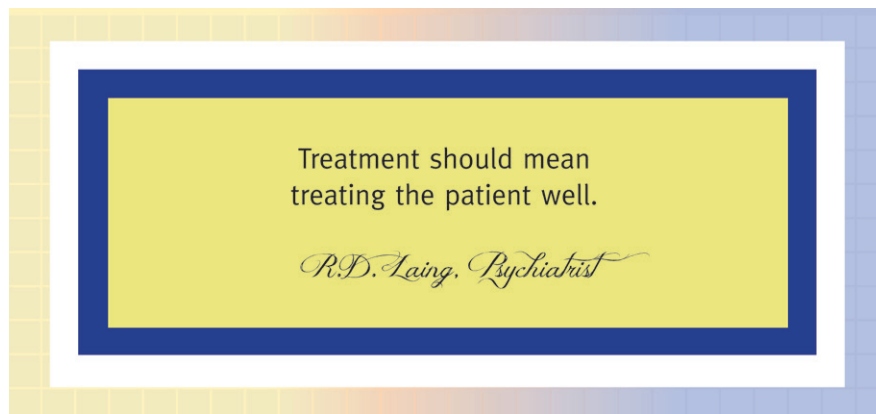
they have persistent, debilitating, and increasingly isolating mental health difficulties. However, by far the majority of psychological or mental health difficulties presently categorised within psychiatry and medicine as *mental illness* or *disorder*, do not warrant this kind of pathological insinuation, and exhibit little positive response if any to medical or pharmacological interventions, and need to be addressed in quite different ways.



Do as much as possible for the patient,  
and as little as possible to the patient.

*Bernard Lown, Nobel Prize winner*

When we approach a person with the purpose of detecting a disorder or illness in need of diagnosis, and perhaps treatment, and we use the language which corresponds with this intent (that of disorder and illness), we keep the person at a distance from us, we isolate, simplify and circumscribe the meaning of their life, reducing it to a clinical entity, a psychopathological category. Not bothering with their history, the critical factors of their immediate environment, or the complexity of their experience in relation to these, we squeeze them into a depersonalising and reductionistic diagnostic mould that does not serve their best interests but those of *presumed* economy and convenience.



When we unnecessarily intervene medically or pharmacologically, thinking we are being humane or helpful, we are in fact doing neither, and are more likely to be doing harm.

### **We need to provide appropriate support to people, not paternalistically rescue them**

Individuals have multiple potentialities, are resourceful, and have their own innate capacity for healing and transformation. Accepting a person as a whole, means paying attention to their freedom, responsibility, and competence, and not rescuing them from their experience, but finding a way to supportively accompany them through it. This opens up possibilities instead of closing them off, which tends to occur if they are not encouraged to maintain responsibility for their experience and to respond to their experience, which can reveal meaning and options hitherto unrecognised. This is true even in unalterably difficult circumstances. As holocaust survivor Dr Viktor Frankl once said: we may have little or no control over some things that happen to us, but one freedom that can never be taken away from us is the freedom to choose how we respond.<sup>21</sup> Exercising such a choice is an act of power, one that can be a potent antidote to powerlessness which so commonly diminishes people's mental health. Powerlessness can generate highly corrosive emotions, and is well known for cultivating chronic stress, insomnia, depression, anxiety, and patterns of suicidal thinking.

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Professor of Psychology, Miles Groth, makes an important point, when he suggests that: we need to try and be careful to distinguish between what is developmentally appropriate and inevitable for a person, and what is genuinely threatening them with isolation and compromised function in everyday life.<sup>22</sup> This is a vital distinction: in relation to the former we may need to humanely companion them through their experience, riding out their suffering with them, without trying to rescue them from it or helping them avoid it. In the case of the latter, we may have to intervene and offer an alternate route for them to try out.

In discussing the content of this article with a psychiatrist recently, she offered the following rule of thumb for any professional assisting others with mental health difficulties: *whatever a patient brings to me of their experience, I assume to be normal, and I continue to assume so unless there are compelling reasons to think otherwise.* Intrinsic to this normality is a capacity and expectation of self-responsibility, competence, self-discipline, restraint, and the dignity of causality.

We need to be careful, that in our desire to help, we don't presume to rescue a person from the very experience that might otherwise give rise to an adaptive and helpful shift in their thinking and experience, depriving them of, rather than enhancing their quality of life.

Even in severe difficulty, people rarely need to be rescued from their experience, but may need to be supported and companioned through it, so that they can be kept safe and respond to it adaptively.

Diagnosing mental illness in many cases, risks consigning people to psychological sedentariness, and dependence on psychotropic medication. Given the near absence of efficacy of such medication (except in some cases of severe mental health difficulty), patients are unwittingly surrendered to the whims of their 'condition' and a revised self-narrative and self-identity coupled with a trajectory of undeserved dependence and frailty; they are encouraged to exchange an internal locus of control and autonomy for an external one; and we call this promoting mental health?<sup>17</sup>

### **The role of complexity in making life difficult and sometimes overwhelming**

Another way of conceptualising acutely challenging, difficult, and sometimes debilitating human experience, is to recognise the role of complexity. If a person is overwhelmed with stressors (apparent causes of stress) and challenges beyond their adaptive capacity to keep everything under some sort of control and to maintain an internal equilibrium, and if they are severely decompensated by their experience, their weakest point of physical or psychological susceptibility is what will breakdown under the pressure; they will likely succumb in the direction of their greatest weakness, whether that means an undesirable gene is switched on, mood becomes disturbed, anxiety sets in as an intolerable burden, or a compromised immune response leads to sickness.

This idea of complexity that overwhelms is useful to consider alongside the mental health diminishing effects of powerlessness; both cause much suffering. Both likewise respond well to companioned problem solving, purposive acts of power, and being able to achieve order, perspective, and a sense of feeling back in control.

Exposed to, yet assisted through such an experience, people may learn new skills and develop a greater capacity of resilience. It takes little imagination to understand why a 10-minute or even a series of 10-minute medical consultations will be an inadequate response to such complexity, or why pharmacologic sublimation of symptoms will achieve little except to prolong a condition that is neither extraordinary, insurmountable, nor necessarily chronic in potential, given time, patience, and appropriate support.

### **Side-lining crucial lifestyle changes with the offer of medication**

In Australia, as with other western societies, an emphasis on illness and drug treatment have eclipsed considerations of lifestyle change, self-help and psychotherapy, despite these being almost always more beneficial. Approaches such as light exposure therapy, structured daily physical activity, reduced alcohol consumption, a balanced diet, and measures to improve sleep.<sup>23, 24, 25, 26, 27, 28, 29, 30, 31</sup> Too often, even when such measures are recommended to patients they are not a first line approach but an adjunct to medication and are thus perceived as recommended but non-essential alongside the more medically definitive drug prescription. Since they also require more time and effort, they come a poor second to the presumed (and marketed) efficacy of a purpose-designed anti-depressant drug.

Professor Peter Gotzsche argues that the current usage of psychotropic drugs could be reduced by 98% and at the same time improve people's mental health outcomes and survival. In relation to antidepressants (amongst the most widely and frequently prescribed drugs), he further argues that such medications turn many self-limiting episodes into chronic ones.<sup>17</sup> In relation to the most popular antidepressants, the SSRI group of drugs, he forthrightly cites the little

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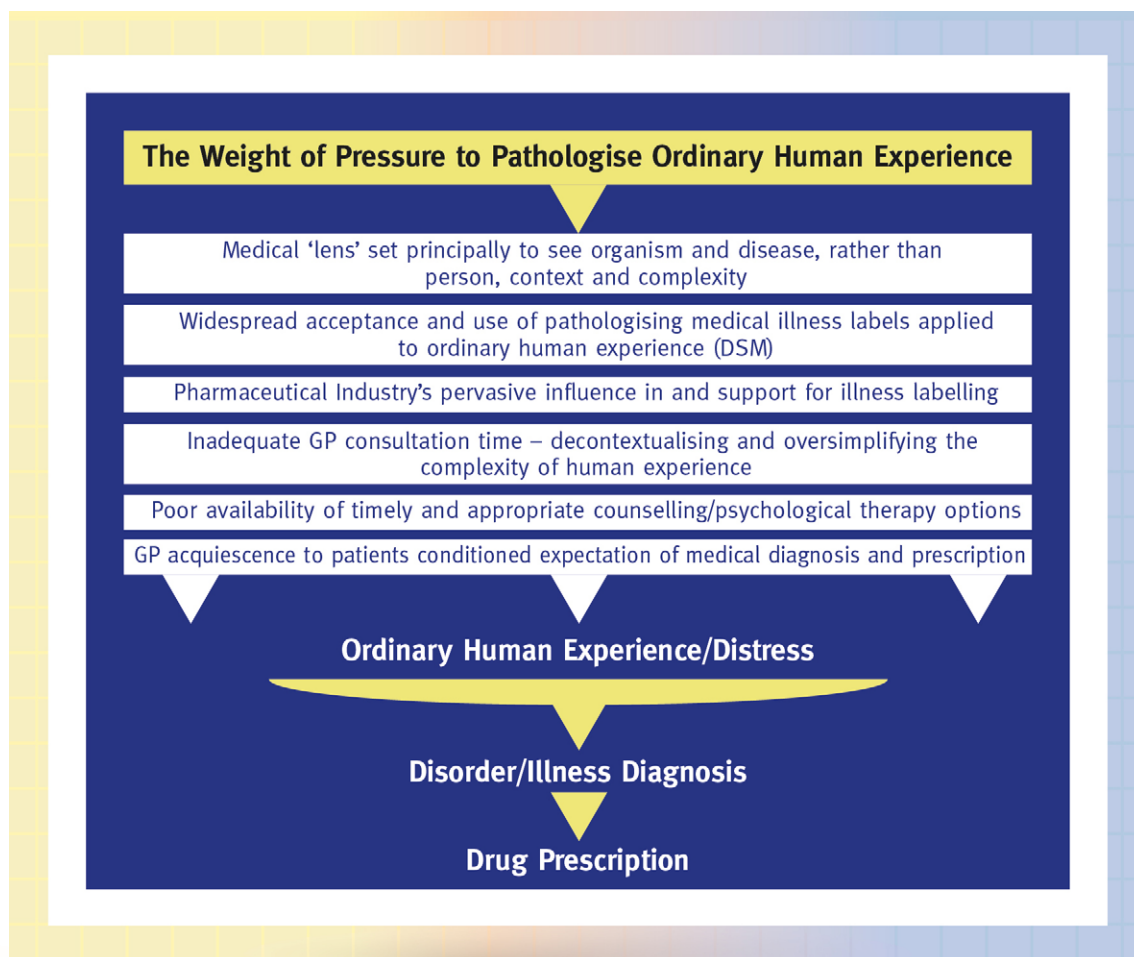
known meta-analytical data of six research trials (718 patients) which suggest that:

*...selective serotonin reuptake inhibitors (SSRIs) were ineffective for both mild, moderate and severe depression, and even for patients with very severe depression, the effect corresponded to only 3.5 on the Hamilton scale, which is well below what is a minimal clinically relevant effect.<sup>32</sup>*

## The high cost to tax payers and industry of mental illness labelling

The medicalisation of human distress, promoted by high profile and heavily funded mental health literacy initiatives and mental health services, not only has profoundly negative implications for unwitting consumers caught in its web (and deemed 'mentally ill'), but as well for the functionality and economy of our mental health system. The estimated cost of mental ill-health to Australia is around four per cent of GDP or about \$4,000 for every tax payer.<sup>33</sup> That this system is overwhelmed by demand and not serving consumers well is a much-discussed issue amongst the general public and in the media. Unsurprisingly, the present mental illness paradigm appears to have led our mental health system into economic and service delivery crisis. Things are little different in the UK which foots the bill for a similarly dysfunctional approach to 'mental health' to the tune of between £70 to £100 billion a year.<sup>34</sup>

The big losers in all of this are of course unwitting consumers, tax-payers, and corporate insurance industry providers who carry a huge financial burden due to the present mental health system. All are bearing the brunt of an indefensible narrative of mental illness and a flawed model of mental health, that show little regard for standards of evidence or ethical human service practice.





## Suicide prevention efforts bedevilled by the mental illness narrative

A significant consequence of an eagerness to diagnose mental illness in people experiencing psychological distress, unfortunately turns up in the field of suicide prevention, and may well be putting people at greater risk of suicide. This is because suicide prevention initiatives, preoccupied with detection of 'mental illness' – such as depression, often overlook and fail to address forms of distress that don't constitute any kind of illness or disorder, and yet which can result in suicidal ideation (thoughts preoccupied with suicide) and suicide.

The current mental illness narrative evident in mental health literacy messaging and commentary on suicide prevention, has tended to reinforce the idea that suicide should, in most cases, be considered to be the result of mental illness or disorder. However, evidence does not support this claim. Whilst conditions like major depression may sometimes be implicated in cases of suicidal ideation and death by suicide and are an important consideration in the design of appropriate preventative measures, this should not be considered license to assume an association between the two that is simply unsupported.<sup>35</sup> Limiting preventive strategies to those built upon the unfounded presumption of mental illness or disorder will simply not help many, perhaps the majority, of those at risk of suicide.<sup>36</sup>

The experience of being human can sometimes be acutely distressing, even overwhelming and debilitating. Nevertheless, even when such experience tests the limits of endurance and adaptive capacity of the individual, it does not constitute a diagnosable illness but more a condition demanding the individual's assiduous attention, acknowledgment of the imperatives of change and adaptation, use of self-help strategies, learning new insights and skills, a willingness to procure social support, and, when necessary utilising the knowledge and skills of a professional counsellor or psychotherapist. By far the majority of mental health difficulties benefit most from these measures *not* from medical intervention or psychotropic medication.

**Nevertheless, even when such experience tests the limits of endurance and adaptive capacity of the individual, it does not constitute a diagnosable illness but more a condition demanding the individual's assiduous attention**

It is not at all simplistic to suggest that much of our mental health system apparatus could be dismantled, and prescribing drugs especially for high prevalence mental health difficulties could almost cease, if instead we opted for an evidence-based approach to dealing with human distress and psychological difficulty; an approach that acknowledges the innate capacity of each individual to recover from their distress and difficulty, if accompanied by timely and appropriate social and, if necessary, professional support. Madness is least of all to be found in individuals, but alas, it does characterise our present cultural and institutional approach to mental health.

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\*This *Situational Approach* does not downplay the importance of professional expertise in mental health, but proposes that this expertise be refocused, so that people with complex and very challenging mental health difficulties, are properly supported in environments and ways that focus on self-efficacy and recovery, without being unduly pathologised or diminished in dignity. However, at the same time, this approach proposes the activation of new sources of capacity – both community and professional, for promotion, prevention, and early intervention for mental health, and emphasises the importance of altering the balance of preventative mental health and suicide prevention with primary and secondary prevention being given primacy.

See: Ashfield, J., Macdonald, J. and Smith, A.

“A ‘Situational Approach’ To Suicide Prevention”. (2017): n. pag. Web. 31 May 2017.

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