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A philosophical investigation into coercive
psychiatric practices

2 Volumes

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Volume 1 of 2

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Abstract

This dissertation seeks to examine the validity of the justification commonly offered for a coercive¹ psychiatric intervention, namely that the intervention was in the ‘best interests’ of the subject and/or that the subject posed a danger to others. As a first step, it was decided to analyse justifications based on ‘best interests’ [the ‘*Stage 1*’ argument] separately from those based on dangerousness [the ‘*Stage 2*’ argument]. Justifications based on both were the focus of the ‘*Stage 3*’ argument.

Legal and philosophical analyses of coercive psychiatric interventions generally regard such interventions as embodying a benign paternalism occasioning slight, if any, ethical concern. Whilst there are some dissenting voices even at the very heart of academic and professional psychiatry, the majority of psychiatrists also appear to share such views. The aim of this dissertation is to show that such a perspective is mistaken and that such interventions raise philosophical and ethical questions of the profoundest importance.²

The philosophical well-spring of the *Stage 1* dissertation argument lay in an observation made by Philippa Foot³ that the “... *right to be let free from unwanted interference*” is one of the most fundamental and distinctive rights of persons, a right which takes precedence over any “... *action we would dearly like to take for his sake.*” This – in conjunction with the recognition that some coercive psychiatric interventions are of a gravity as to result in the personhood of the subject being severely damaged if not destroyed – suggested that the concept of personhood play a central role in the formulation of the dissertation argument. For ease of analysis it was presumed that the term ‘person’ could be defined by a set of necessary and sufficient conditions of which ‘minimum levels of rationality’ and ‘ability to communicate’ were the only conditions relevant to the formulation of justifications for coercive psychiatric interventions. This presumption was explicated into a number of postulates which enabled the construction of a rigorous foundation on which to develop the dissertation argument.

This argument then sought to determine whether psychiatric assessments of irrationality were accurate and reliable. In furtherance of this analysis it was necessary to examine the reliability of psychiatric determinations in other areas of claimed expertise namely diagnosis, treatment and assessment of dangerousness. This ‘crossing of the disciplinary threshold’ brought to light the dearth of studies on psychiatric misdiagnosis and iatrogenic harm. A variant of the *Precautionary Principle* was developed to enable the extent of such harms to be estimated. The not insignificant levels of psychiatric misdiagnosis and iatrogenic harm and erroneous assessments of dangerousness which were thus found are of considerable relevance to any ethical analysis of the justification for coercive psychiatric intervention and serve to undermine simple paternalistic justifications.

¹ The term ‘coercive’ (rather than ‘non-consensual’) is used to indicate an intervention carried out against the explicit and contemporaneous objections of the subject.

² Not least because the number of individuals detained in Irish psychiatric hospitals is of a comparable order of magnitude to the number detained in Irish prisons subsequent to a criminal conviction.

³ See Foot (1977), p.102.

Declaration

I hereby declare that this thesis is the result of my own original research and that it does not contain the work of any other individual. All sources that have been consulted have been identified and acknowledged in the appropriate manner.

Gerry Roche

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⁴ Tables are numbered and include a chapter or appendix reference, thus Table 1-2 is the second table in Chapter 1; Table F-3 is the third table in Appendix F.

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An image from an abandoned mental hospital

Introduction

*They are begging us, you see, in their wordless way,
To do something, to speak on their behalf
Or at least not to close the door again.*

Lines from a poem by Derek Mahon¹

Imagine the following scenario: a man runs down a crowded street, shouting wildly, threatening those about him and brandishing a knife; he is apprehended and detained by a policeman. It is difficult to imagine circumstances where the action of the policemen could be challenged solely on ethical grounds.

Variants on such a scenario – though perhaps not as dramatic – are, at least in the public mind,² paradigmatic of those situations which warrant intervention by a psychiatrist even if this be non-consensual. Viewed from such a perspective, the actions of such a psychiatrist would seem even less open to challenge on ethical grounds, than that of the policeman especially as the psychiatrist – being a physician – is perceived to be acting in the ‘best interests’ of the subject. Furthermore – in that psychiatry is presumed to have access to mechanisms of diagnosis which are rigorously defined and a range of treatments which are securely grounded in evidence based studies – the psychiatrist’s determinations are clad in the raiments of science and are thus given an additional authority.

Legal³ and philosophical analyses of non-consensual psychiatric interventions generally concur with such a perspective, regarding them as embodying a benign paternalism occasioning slight, if any, ethical concern. Whilst there are some dissenting voices even at the very heart of academic and professional psychiatry, many psychiatrists also appear to share such views.

The aim of this dissertation is to show that such a perspective – though in accord with the conventional wisdom – is mistaken and that such interventions raise philosophical and ethical questions of the profoundest importance. Though the general tenor of the dissertation argument, in that it focuses on problematic aspects of non-consensual psychiatric intervention, may appear to argue against all such interventions, this is most certainly not the case as will be seen in the dissertation conclusions.

¹ Excerpt from ‘A Disused Shed in Co. Wexford’. [Mahon (2006), p.39]

² See, for example, the discussion in Chapter 6 concerning the portrayal of mental illness in the popular media.

³ I refer here to the Irish courts.

In advocating such a contrarian stance, I am mindful of the evidential burden that I have undertaken but I am also conscious that the perceptions of some of those who have subsequently recounted their own experiences of being subjected to a non-consensual psychiatric intervention are radically different from the benign paternalism spoken of earlier. An ethical assessment of non-consensual psychiatry – if it is to make any claim to adequacy – must make room for these alternative perspectives which often focus on the experience of the subjects as being treated by psychiatrists, as ‘objects’ or ‘non-persons’. One goal of this dissertation is to widen the usual philosophical analysis of psychiatric interventions so that issues as to personhood – its propensity to being damaged and consequently, the need for its protection – are center stage.

Before outlining the structure of the remainder of this Introduction, I wish to give three examples of such alternative perspectives:

Example 1: Richard Bentall who is Professor of Clinical Psychology at the University of Manchester, drawing on his own experiences, writes in the preface to his *Madness Explained*: “... psychiatric patients have been denied a voice by being treated as irrational and dangerous, like wild animals in a zoo.”⁴

Example 2: Ronald Bassman,⁵ who subsequently practiced as a clinical psychologist for over twenty years, describes his first meeting with his psychiatrist:

His bored air and mechanized rote manner of relating to me expressed an undisguised arrogant superiority towards a nonperson. I was an object to be acknowledged, but unworthy of respect.⁶

And his experience of a forced hospitalization:

Once hospitalized, you are marked with a diagnosis and that label becomes an indelible tattoo burned into your sense of self. Worse still was the knowledge that I could be stripped of everything: memory, identity, dreams, ideals, freedom to move or even to think. All this could be brought about with my tormenters feeling self-righteous, and those who cared for me thinking they were acting in my best interests.⁷

Example 3: The National Council on Disability⁸ in its report on coercion in the US mental health system, having heard the accounts of ex-psychiatric patients, stated:

The overwhelming amount of testimony concerned the harmfulness of involuntary interventions on people’s sense of dignity and self-worth, and, further, contended

⁴ Bentall (2003), p.xiv.

⁵ This and other examples given in this Introduction are discussed in later chapters.

⁶ Bassman (2000), pp.1397-8.

⁷ *Ibid.*, pp.1401-2.

⁸ The National Council on Disability (NCD) is a US Federal agency empowered by law to provide policy recommendations to the President and Congress on issues involving disability.

that such interventions were seldom helpful in assisting people either with their immediate problems or with their long-range ability to improve their lives.⁹

The structure of the remainder of this Introduction is as follows:

Section A: Terminological issues;

Section B: The numerical frequency of coercive psychiatric interventions;

Section C: Common legal attitudes towards coercive psychiatry;

Section D: Some dissenting voices from within psychiatry;

Section E: ‘Crossing the threshold’ of psychiatry;

Section F: Outline of the argument to be developed.

Section A: Terminological matters

Inappropriateness of the term ‘non-consensual’

The use of the term ‘non-consensual’ requires reconsideration in that non-consensual, non-psychiatric, medical intervention is legally permitted in certain situations and the aim of the present analysis requires that those interventions which are peculiar to psychiatry be isolated and distinguished from permissible non-psychiatric medical interventions.

An example of a non-consensual medical intervention would be the giving of life preserving treatment to the unconscious victim of a car accident. The issue is problematic because, in the absence of consent, any such medical treatment – when viewed from a legal perspective – constitutes an assault.¹⁰

Before this theme can be explored, an issue which is fundamental to the approach to be adopted in this dissertation must first be clarified: non-consensual psychiatric intervention can be addressed wholly from within a legal framework of statutes, case law and constitutional interpretation; it can also be addressed from a philosophical perspective; how, for the purposes of this dissertation, should these differing viewpoints be reconciled?

A purely philosophical approach – one which ignored the current legal position in relation to non-consensual psychiatric intervention – might seem attractive in its directness, however such an approach would be at best superficial, and at worst risk degenerating into a pointless analysis of possible psychiatric interventions which (although, perhaps, even having a basis in historical fact, such as the ‘ice-pick’ lobotomies carried out in such a cavalier fashion by Dr. Walter Freeman in the US in

⁹ National Council on Disability (2000), p.25; these accounts were not claimed to be a representative sample of all such patients. See Chapter 7 (Subsection C.3) where some studies which sought to evaluate subjects’ retrospective assessments of having been subjected to coercive treatment, are discussed.

¹⁰ Though the doctrine of legal necessity may provide a defence.

the 1950-60s) now lie outside the pale of permissible psychiatric practice. There is no point in seeking an ethical justification for psychiatric practices of a bygone age. It is clear that the analysis must be grounded in the present law; however, the detailed exposition of Mental Health Law is a complex task best left to legal scholars.¹¹ The standpoint which I have decided to adopt in relation to legal matters, is that of an interested and informed lay person and that where the dissertation argument touches on particular legal provisions (*e.g.* whether a coercive psychiatric intervention requires prior judicial approval) to take the position under Irish law as the default position¹² in regards to the making of what is, at base, a philosophical and ethical – and not a legal – argument.

Cases similar to the unconscious accident victim might well occur in psychiatric practice as, for example, when a patient having taken a drug overdose is unconscious or is so traumatised as to be unable to communicate. To emphasise the exclusion of such cases, the expression ‘*coercive psychiatric intervention*’ will be used rather than ‘*non-consensual psychiatric intervention*’ in that it connotes an intervention carried out not only without the consent of the subject but in the face of clear demands by the subject that the intervention not take place.

The terms ‘diagnosis’, ‘treatment’ and ‘patient’

Some of the terms used in relation to coercive psychiatric intervention – *e.g.* ‘diagnosis’ and ‘treatment’ – import an aura of precision and exactitude and of beneficence that facilitate the adoption of paternalistic attitudes, attitudes which are reinforced by use of the term ‘patient’ which also carries the implication that the individual in question has been assessed as being ‘a suitable case for treatment’. The term ‘dangerousness’ – especially in the context of a psychiatric risk assessment based on a numerical scale – is similarly capable of importing a spurious aura of exactitude.

The Norwegian criminologist Nils Christie has noted that: “*Words are a good means of disguising the character of our activities*”;¹³ and offers the term ‘treatment’ as an example and shows how in relation to drunkenness, its ‘treatment’ rather than its punishment enabled the use of harsher methods.¹⁴

¹¹ See, for example, O'Neill (2005).

¹² Irish Law in relation to coercive psychiatric intervention should not necessarily be taken as being representative of the law of other European countries; Belgian law, for example, is considerably more proactive. Priebe (2010) contains an appendix that shows the wide variation in legal rights in relation to coercive psychiatric intervention, that exists across a sample of 11 European countries.

¹³ Christie (1981), p.3.

¹⁴ *Ibid.*, p.6. See also how US medical personnel described the ‘waterboarding’ of terrorist suspects, as a ‘treatment’: “... *guidelines ... that they document each time a detainee was waterboarded, ... whether the detainees’ breathing passages were filled, and how each detainee looked between treatments.*”

The ethicist Walter Reich (1999) in his examination of the social role played by psychiatric diagnosis, speaks of “*the beauty of diagnosis as a solution to human problems*”;¹⁵ one of its ‘beauties’ being:

... its power to reclassify whole categories of socially unacceptable behaviour as the products of psychiatrically diagnosable conditions. ... and psychiatrists, whose redefinitions make all this possible, and who can feel themselves in the noble position of healing where others would have only hurt.¹⁶

In embarking on this dissertation, it is necessary that – in Christie’s telling phrase – this ‘*veil of words*’ be punctured so that the nature of a coercive intervention can be seen in its unadorned starkness; accordingly, it would be advisable to speak not of ‘diagnosis’ and ‘treatment’, but of how ‘*some people are picked out*’ and how, having been chosen, ‘*things are done to them*’.

Lest such a proposal seems extreme and unwarranted, the not insubstantial rates of psychiatric misdiagnosis, harmful treatments and erroneous assessment of dangerousness (to be discussed in later chapters) should be borne in mind.

However – the point having been made and in the interests of greater readability – the terms ‘diagnosis’ and ‘treatment’ will be used in the remainder of the discussion; the term ‘subject’ (as in one *subjected* to a coercive intervention) will be used in place of the term ‘patient’.

Section B: Coercive psychiatric interventions: numerical extent and some collateral effects

B.1: Numbers involuntary detained vs. committals to prison

Mental Health Tribunals which were established under the *Mental Health Act* (2001), became operative in 2006 and because the advent of these tribunals resulted in a “*a 25% reduction on the number of people admitted on an involuntary basis*”¹⁷ it is of interest to take years both before, and after, 2006. I have taken the years 2004 and 2009 for purposes of comparison.

2004

In 2004 there were 3,162 involuntary committals to mental hospitals in the Republic of Ireland.¹⁸ By way of comparison, in that same year there were 5,064 committals to

Risen, J. (2010). ‘Study Cites Breaches of Medical Ethics Against Terror Suspects.’ *The New York Times*. 6 June. [Emphasis added]

¹⁵ Reich (1999), p.205.

¹⁶ *Ibid.*, p.209.

¹⁷ MHC (2007), p.8.

¹⁸ MHC (2004), p.34, Table 7.

prison under sentence.¹⁹ Thus, in 2004, for every 100 committed to prison, over 62 were involuntarily committed to mental hospitals; however this underestimates the extent of coercive detention in that it does not include the “*de facto detained*”²⁰ who comprise:

- those who, under explicit threat of being compulsorily detained, ‘consent’ to admission as a voluntary patient; and
- those who, though (legally) ‘voluntary’, have been led to perceive themselves as being under constraint.²¹

2009

There were 10,865 committals to prison under sentence, in 2009²² and 2,024 involuntary admissions to mental hospitals.²³

The reduction in the committals as a percentage of convictions can be accounted for partly by the advent of the Mental Health Tribunals but more importantly by the rapid increase in the number of committals to prison, for example, the 2009 figure was a 35% increase on that for 2008.

The numerical extent of coercive psychiatric interventions mark the problem as one worthy of investigation especially when the elaborate mechanisms of the criminal law which are designed to ensure that no innocent person is convicted, find but the meagrest of counterparts in the systems in place to ensure that no one is wrongfully committed to a mental hospital.

B.2: Some collateral effects of coercive psychiatric intervention

A coercive psychiatric intervention may have unintended, but serious, consequences for a subject because of the stigma consequent on psychiatric committal and also because of the not inconsiderable possibility of iatrogenic harm due to psychotropic medication. In psychiatry, as in general medicine, misdiagnosis may occur but with the additional possibility that it may precipitate a coercive intervention. The limited possibilities of redress for one wrongfully subjected to a coercive psychiatric intervention²⁴ compounds

¹⁹ Irish Prison Service (2004), p.10.

²⁰ Keys (1999), p.116.

²¹ See, for example, Iversen (2002).

²² Irish Prison Service (2009), p.3.

²³ MHC (2009a), p.29. Thus in 2009, for every 100 imprisoned 19 were involuntarily confined.

²⁴ Under the *Mental Health Act* (2001), S.73 it is necessary for an applicant to first seek leave of the High Court to begin legal proceedings and then to establish that the harm suffered was due to the psychiatrist acting in “*bad faith or without reasonable care;*” negligence, *simpliciter*, is not sufficient; see also Appendix A.

this danger, as does the extreme difficulty in getting a psychiatric diagnosis, once made, revisited.

In summary, the number of coercive psychiatric interventions and the possibly serious consequences of such interventions (especially if grounded in a misdiagnosis) are such as to mark the analysis of the justification for coercive intervention as a problem requiring urgent study. Furthermore, such a study requires principally a philosophical – rather than a legal or psychiatric – approach as it is from within philosophy that a perspective can best be developed which is adequate to effect some measure of reconciliation between the use of coercive psychiatric interventions and their effect on the integrity of the human person subjected to such interventions.

Section C: Some legal and philosophical perspectives towards coercive psychiatric intervention

C.1: Some legal perspectives

In that both involuntary committal to a mental hospital and imprisonment subsequent to a criminal conviction both involve a loss of liberty, it is of interest to contrast the attitude to the courts to technical breaches of legislative safeguards in the context of a criminal trial [*C.1.1*] to attitudes in the context of an involuntary psychiatric committal [*C.1.2*] and to the (inevitable) errors that occur when either guilt is determined or mental illness precipitating an involuntary committal, is diagnosed. [*C.1.3*].

C.1.1: Technical breaches of safeguards under the criminal law

The case of Judge Brian Curtin provides an excellent example of how the courts respond to technical breaches when detention under the criminal law is in prospect. A search warrant had been issued in relation to Curtin's home, pornographic images of children had been found on his computer and he had been charged with their possession. The trial judge held that the search warrant had been defective; it had been issued at 3.20pm on 20th May 2002 and was valid for seven days; the trial judge held that 'days' did not mean periods of 24 hours but actual days and that consequently its attempted use at 2.20pm on 27th May rendered the search, and any evidence obtained under it, illegal. The prosecution failed.²⁵

This decision is a manifestation of a wider legal principle namely, that any trespass in excess of the strict conditions imposed by law or any wrongful detention of even the

²⁵ The Irish Times (2004), 'Outcome of case inevitable, says judge'. *The Irish Times*. 24 April.

shortest duration, is considered by the courts to be a ‘damage’ to be countered with the full rigor of the law.

C.1.2: Technical breaches of safeguards in the Mental Health Acts

A radically different attitude is shown by the courts to technical breaches of the protective provisions of legislation when detention under the Mental Health Acts is in prospect. The courts view psychiatric interventions as essentially paternalistic in character²⁶ and – absent any evidence of ‘bad faith’ – a psychiatric intervention undertaken under the umbrella of ‘best interests’ is accepted as such and, by implication, as excluding the possibility of damage.²⁷ Considerable indulgence is shown by the courts in adjudicating on the legality of coercive psychiatric detention²⁸ even in circumstances where the, far from onerous, legal requirements have been ignored.²⁹

More recent judgements of the Irish High,³⁰ and Supreme,³¹ Courts have reinforced such attitudes and displayed an intolerance towards arguments which are based either on the breach of the ‘technicalities’ of the Mental Health Acts or which seek to give precedence to the liberty of the individual:

²⁶ See, for example, the Supreme Court judgment in *Gooden v Waterford Regional Hospital* (2001), where provisions of the *Mental Treatment Act* (1945) were unsuccessfully challenged, Hardiman J. stating that:

I do not know that I would have been prepared to go as far as we have in this direction were it not for the essentially paternalistic character of the legislation as outlined in *In re Philip Clarke* [1950] [O’Neill (2005), p.97.]

²⁷ It is of interest to note that in other situations where a coercive medical intervention might be thought to be justified on the grounds of ‘best interests’ (e.g. forced caesarean section, treatment of infectious diseases, mass immunisation), not only is the medical consensus against any coercive intervention, but such interventions also attract the rigorous scrutiny of the courts. [See Appendix A]

²⁸ The deference shown by the courts to psychiatric testimony in such cases, does not always extend to other areas of the law as, for example, to criminal trials especially when there is a conflict of psychiatric evidence. In the Brendan O’Donnell case, for example, the court was “... scathing [in its] criticism of psychiatric professionals.” [Murdock (1996).]

²⁹ For example, in *Orton v St. John of God Hospital* (2004) the applicant had submitted that the requirements of the *Mental Treatment Act* (1953) had not been complied with. The High Court held that: “If the substantive requirements of the Act are complied with, ... I am satisfied that this is sufficient compliance.”

³⁰ See, for example, *Z. v Khattak & Anor* (2008) where the medical examination (on which the detention was grounded and which had been undertaken by a Dr. W) consisted of a chat between the applicant, a guard and Dr. W whilst they smoked a cigarette. Dr. W did not take notes of the discussion, and admitted in court that he did not know what a mental state examination might entail.

The court found that:

[Dr W] described the applicant as being “up in the clouds and then was down again”, and in relation to the applicant’s denials that he was mentally ill or not taking his medication he stated that “they are all the same” and that “like most of them they deny that anything is wrong”.

... even though I would have reservations ... nevertheless one cannot discount completely the probability that Dr W’s thirty years’ experience as a general practitioner ... enables him to reach the necessary conclusions ... I cannot doubt the basis on which Dr. W made his recommendation.

³¹ *E.H. v St. Vincent’s Hospital & ors* (2009).

We do not feel called upon by authority or otherwise to apply to this case the sort of reasoning that would be applied if it were a criminal detention and to investigate whether previous matters which might have a causal relationship to the present detention are invalid.³²

The court appears not to have been cognisant of the possibility that by virtue of its harsh criticism³³ of the technical grounds on which the proceedings were based, encouragement is given to others, in more contentious cases, to dispense with the strict requirements of law.

The court cited, with approval, earlier court decisions which emphasised the paternalist nature of mental health legislation stating:

... the statute of 2001 is a scheme of protection, and a very elaborate and very necessary scheme of protection, because of course everyone, even from general knowledge, is aware of the serious misuse of the power to detain people in mental hospitals which have taken place in fairly recent times in other jurisdictions.³⁴
[Emphasis added]

Manifestly lacking in these judgements, is any indication that the courts entertain even the remotest possibility that a wrongful psychiatric incarceration or a psychiatric detention precipitated by a psychiatric misdiagnosis, might occur (or have occurred) in its jurisdiction.³⁵ This is especially clear in the court's use of the term "*other jurisdictions*" in the passage just cited, and brings to mind Lord Denning's "*appalling vista*" argument³⁶ to the effect that the consequences of a proposition being true are so appalling, that one must conclude that they are not true – a less than satisfactory basis for conducting a rational argument especially in relation to mental health. Such an approach is also evident in the passage from *In re Philip Clarke* (1950) (*supra*) – often cited with judicial approval – which uses the phrase "*alleged to be suffering from such infirmity*"³⁷ rather than "*suffering from such infirmity*" which eloquently bespeaks the unwillingness of the Irish judiciary to trespass on what it considers to be, psychiatry's dominion.

A further point in relation to the attitude of the Irish courts concerns their willingness to '*muddy the waters*' by conflating issues of dangerousness and paternalism³⁸ which

³² *Ibid.*, citing *Cudden v The Clinical Director of St. Brigid's Hospital* (2009).

³³ *Ibid.*:

These proceedings were initiated and maintained on purely technical and unmeritorious grounds. It is difficult to see in what way they advanced the interests of the applicant who patently is in need of psychiatric care.

³⁴ *Ibid.*, citing *RL v Director of St. Brendan's Hospital* (2008).

³⁵ Despite clear evidence that such cases have occurred; see, for example, the Manweiler case.

³⁶ See, for example, Cohen, N. (2004) 'Schooled in Scandal'. *The Observer*. 1 February.

³⁷ Emphasis added.

³⁸ See, for example:

- [*Gooden v St. Otteran's Hospital* (2005) (*supra*): "*This situation [i.e. his release] would apply even if the patient in question was so mentally ill as to be a danger either to himself or the public.*"

severely compromises the rigor of the intellectual stance adopted; the argument to be developed in this dissertation (which separates issues of dangerousness from other relevant matters) evolved out of a need to remedy such confusions.

C.1.3: Contrasting attitudes of the courts to error in criminal conviction and psychiatric committal

Misdiagnosis is a well-recognised phenomenon³⁹ in non-psychiatric medicine and – in that psychiatry has no access to the battery of definitive biological and other tests⁴⁰ that are so readily available in non-psychiatric medicine – it might reasonably be expected that the incidence of misdiagnosis in psychiatry is no less than in non-psychiatric medicine. A psychiatric misdiagnosis may well precipitate a coercive psychiatric intervention leading to loss of liberty yet neither the psychiatric profession nor the legal system appear to be fully cognizant of the possibility of such serious eventualities: for example, the Mental Health Tribunals which were established under the *Mental Health*

- [*In re Philip Clarke* (1950) (*supra*): “ ... alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others.”

The appeal to dangerousness is something of a subterfuge in that, for example, a suspect charged with a particular gruesome assault, on evidence which is compelling (*e.g.* a detailed confession) but which was obtained by virtue of a technical breach of the law (*e.g.* the case of Judge Brian Curtin, *supra*) will nonetheless be set free though clearly presenting a high level of danger to others.

³⁹ Appendix I, which examines estimates of iatrogenic harm and misdiagnosis in general medicine, concludes, *inter alia*, that:

- A conservative estimate of the rate of misdiagnosis in general (*i.e.* non-psychiatric) medical practice in Ireland is in the region of 25%.
- The rate of iatrogenic harm occurring in Ireland is at least comparable to that of the US.

The Harvard Medical Practice Study on iatrogenic harm in US hospitals [Brennan (1991)] found that: Results: Adverse events occurred in 3.7% of the hospitalizations ... and 27.6% of the adverse events were due to negligence ... Although 70.5% of the adverse events gave rise to disability lasting less than 6 months, 2.6% caused permanently disabling injuries and 13.6% led to death. ... (p.370)

More recent reports from the US covering the years 2002-2007, found that the incidence of iatrogenic harm had not decreased over time. [See, for example, Grady, D. (2010). 'Study Finds No Progress in Safety at Hospitals'. *New York Times*. 24 Nov.]

The data in relation to iatrogenic harm as uncovered in various studies is often difficult to reconcile due to the adoption of conflicting methodologies, differing definitions of 'adverse event' and assessments as to causality; however the following paragraph provides a balanced summary of the overall position:

In the United States, iatrogenic harm was found in 3.7-18% of all non-psychiatric hospitalizations and fatal iatrogenic harm, defined as the medical error or negligence contributing to the death of the patient, was found in 0.47-0.5% [among others Brennan (1991) and Grady (2010) *supra*]. Most adverse events resulted in minor impairment. 27.6-63.1% of iatrogenic harm was estimated to be avoidable. Different definitions of iatrogenic harm and differences in methodology might explain the differences in overall harm (and its avoidability) found. One of the authors of the 1991 study claims that figures in Ireland are even higher, but empirical evidence on the Irish situation is lacking, as is evidence on psychiatric hospitalisations. [Professor Joris Vandenbergh, personal communication]

⁴⁰ According to an editorial in the *American Journal of Psychiatry* [First & Zimmerman (2006)]:

Despite widespread acceptance that most psychiatric disorders are 'diseases of the brain', the field of psychiatry has thus far failed to identify a single neurobiological marker that is diagnostic of a mental disorder. ... Although many candidate laboratory tests have been proposed over the years ... none has been found to be sufficiently sensitive and specific to be suitable for psychiatric diagnosis.

Act (2001) – and in the face of strenuous opposition from the psychiatric profession⁴¹ – whilst they may review a subject’s treatment and detention and may order his release, appear to lack the power to reverse a diagnosis already made. Furthermore an individual who was subjected to a coercive psychiatric intervention consequent on a misdiagnosis attributable to psychiatric negligence⁴² is, on release, precluded from seeking recompense for the damage that he suffered. This provides a stark contrast to the attitude adopted by the courts in dealing with criminal matters where the courts are not only cognisant of the possibility of a wrongful conviction but the criminal legal system is structured in such a fashion as to ensure that this possibility is minimised.⁴³ It is difficult to find grounds to explain the contrasting attitudes adopted by the Irish Courts to cases of psychiatric misdiagnosis leading to an involuntary committal, and cases of wrongful conviction leading to imprisonment, other than that the psychiatric intervention is assumed to be motivated by the ‘best interests’ of the subject (and hence to be, unequivocally, to his benefit), whereas the motivation for imprisonment is the punishment of the subject (and hence, presumably, to his detriment).

Some legal commentators, however, are sceptical of any such analysis and have suggested that the deferential attitude adopted by the courts towards coercive psychiatric interventions flow from less altruistic motives:

Judicial reluctance ... is arguably indicative of a criminal justice system content to sweep the ethical dirt under the legal carpet in a pragmatic desire to leave difficult decisions about what to do with the weak and socially unproductive to those whose practices are least subject to scrutiny.⁴⁴

A mask of disinterested benevolence has often served as a cover for other interests,⁴⁵ but even in cases where no such hidden interests are involved, is an intervention in the life of another on the grounds of their supposed ‘best interests’, an adequate ground? This question lies at the heart of the argument to be developed in this dissertation.

C.2: Some philosophical perspectives

In contrast to non-psychiatric medicine, the use of coercion is perhaps the most ethically distinctive feature of psychiatry and for that reason it might be expected to be the central focus of philosophical writings on psychiatry, yet – with some notable exceptions – the topic features but rarely. Discussion of the relevance of rates of

⁴¹ Raftery, M. (2005). ‘Psychiatric profession at it again’. *The Irish Times*. 26 May.

⁴² As distinct from ‘bad faith or without reasonable care’. [See Appendix A]

⁴³ The legal maxim “*Better that ten guilty persons escape than that one innocent suffer*” attests to such attitudes.

⁴⁴ Wilson & Smith (1995), p.405.

⁴⁵ As occurred, for example, in the 19th century imperialist interventions in Africa.

psychiatric misdiagnosis or iatrogenic harm, to possible ethical justifications for the use of coercion in psychiatry, is even less common.

Of the notable exceptions, Michel Foucault is preeminent yet his critiques are of a level of generality that – with the exception of his analysis of psychiatry’s claim to being a ‘science’⁴⁶ and of the use of psychiatric expert evidence in criminal trials⁴⁷ – that they have not been of use in framing the dissertation argument.

Anthony Kenny is another notable exception. Kenny in criticising the then current Mental Health legislation which, he argued, manifested “*a Platonic enthusiasm for the replacement of judges by doctors.*”⁴⁸ argued that:

The humane and benevolent optimism characteristic of this approach is not incompatible with a certain ruthlessness in its practical application. ... Obviously, the standards of evidence required to show that someone is a patient requiring treatment do not have to be as rigid as those required to show that he is a guilty man meet for punishment.⁴⁹

A possible consequence is, according to Kenny, that – in a terminology to be clarified shortly – the ‘personhood’ of one subjected to such intervention is damaged or destroyed.⁵⁰

Some other philosophers level a more indirect and sometimes barely perceptible criticism of coercive psychiatry: *e.g.* Binswanger,⁵¹ Habermas⁵² and Gadamer.⁵³

Many other philosophers - especially its sub-discipline ‘*Philosophy of Psychiatry*’ – adopt a deferential stance towards psychiatry resulting in, for example, an uncritical acceptance of its status as a ‘science’. Jennifer Hansen, a member of the Executive

⁴⁶ Foucault terms such claims “*grotesque*” [Foucault (2003), p.11]; see Chapter 4.

⁴⁷ Foucault calls such experts “*buffoons*” [Foucault (2003), p.36]; see also Foucault (1978).

⁴⁸ Kenny (1969), p.24.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*: “*The point is made very early on in the Republic that madmen have no rights: they may not claim their property, they are not entitled to the truth.*”

⁵¹ Binswanger in that he emphasised the importance of communication and of establishing a mutual relationship of trust between therapist and subject. See, for example, Frie (2000), p.21:

Binswanger’s case studies stem primarily from the 1920s and 1930s, when schizophrenics were often seen simply as medical objects to be observed and treated in whatever way possible. Unlike many of his contemporaries, Binswanger viewed his schizophrenic patients as sentient human beings who had lost their sense of relatedness. Like Sullivan, who is similarly known for his work with schizophrenics, Binswanger usually became well acquainted with his patients.

⁵² For example, Habermas (1986), p.369:

The socio-psychological costs of a rationalisation restricted to the cognitive instrumental dimension - costs that are externalised by society and shifted to individuals - appear in different guises, ranging from clinically treated mental illnesses through neuroses, phenomena of addiction,

⁵³ For example, Gadamer (1996):

– ... the loss of personhood. This happens within medical science when the individual patient is objectified in terms of a mere multiplicity of data. (p.81)

– The picture of the individual which is constructed on the basis of standard values is an extremely precarious and unreliable one. (p.160)

Council⁵⁴ of the *Association for the Advancement of Philosophy and Psychiatry* provides one of the more extreme examples of such attitudes:

- The biomedical model is now the way things are done in psychiatry; Freudianism and phenomenological approaches died with the DSM-III. Once something becomes “normal science” there is no time for philosophical debates.⁵⁵
- ... the amazing work that philosophers have done to ... shore up psychiatry against attacks by those who claim it a pseudo-science, ... (p.3)
- The hope is that philosophers and psychiatrists can form a partnership to counteract the growing critics of the field. (p.5)

The same issue of the *Bulletin for the Association for the Advancement of Philosophy and Psychiatry* also contained the following contributions:

Rego (2007):

Within this field of study Thomas Szasz is certainly the world’s most discredited man. And yet he uncritically appears like Aristotle as the basis for an improbable number of discussions about psychiatry. (p.9)

Sadler (2007):

We can understand the profound sense of offence about Dr. Szasz’ writings from the vantage point of the families of the mentally ill. For them, Szasz, is the intellectual promoter of stigma, the blamer of victims, a partner to the Sociology movement. Who could take such dangerous talk seriously. (p.10)

Weiner (2007):

As a mentally ill patient living on disability ... I have had a similar reaction to Szasz ... In the course of my readings I found myself physically unable to touch Szasz’ most famous book, *The Myth of Mental Illness* for fear that I would be rendered not mentally ill but merely disgusting and evil. (p.15)

Hansen appears to be one of those philosophers described by Papineau (2006) who see the role of philosophy as being that of buttressing the status quo whether this is manifested in ‘common sense’ or in professional consensus; Hansen’s enthusiasm to “shore up” psychiatry makes her into an apologist rather than an insightful critic and is reminiscent of the emperor’s minions complementing him on his beautiful clothes – a role surely not appropriate to philosophy.

On the occasions that philosophers of psychiatry⁵⁶ do turn their attention to justifying the use of coercion, they appear to accept a lesser standard of rigor than might normally be expected in philosophical discussion; for example, K.W.M. Fulford (a psychiatrist

⁵⁴ Jennifer Hansen is Professor of Philosophy at St. Lawrence University.

⁵⁵ Hansen (2007), p.3.

⁵⁶ On the role of philosophy in psychiatry see, for example, Neimark (2009):

Typically, explorations into important issues in psychiatry that might help the discipline refine its understanding, explanations, and ultimately its clinical utility tend to deteriorate into either dichotomized nature versus nurture debates or adoptions of bland "biopsychosocial" models, which essentially posit that it's all just really complicated, so why bother? As a result, fundamental questions about psychiatry's philosophical underpinnings remain largely unexamined.

and philosopher of some considerable eminence) in writing about a case of a depressed patient, Mr. A.B., who was possibly suicidal, states:

This case, which is a clinically standard one, shows just how compelling is the moral intuition under which most compulsory treatment is carried out. Although it involves a clear infringement of liberty, few would disagree with the psychiatrist that he had “no option” but to proceed as he did. ... Yet, widely shared as this intuition may be, compulsory treatment, even in a clinically standard case like Mr. A.B.’s, has its opponents. Some have argued that the erosion of liberty involved is simply too high a price to pay for the benefits which such treatment may bring in individual cases (Szasz, 1963). Others, more radical, have seen in it a conspiracy: Foucault, for example, ... has claimed that all compulsory “treatment”, so called, is really a form of political coercion (1973). We may dismiss such claims. We may ... regard as “repellent” the attitude of those who would refuse compulsory treatment even to a suicidally depressed patient like Mr. A.B.⁵⁷

In the seeming absence of an established tradition of rigorous philosophical analysis of the possible justifications for coercive psychiatry, the most pressing problem is to find concepts which will enable a philosophical framework to be constructed within which a fruitful discussion of possible justifications may be possible. This problem will be addressed in Section F (*infra*).

Section D: Some perspectives from within the psychiatric profession

D.1: On the extent of coercive psychiatric practices

The psychiatric justification for coercive intervention is primarily based on the belief that psychiatric treatments and diagnostic procedures are securely grounded in evidence-based studies, thus ensuring that psychiatrists are in the optimal position to judge both the best interests of a subject diagnosed with a mental illness and the particular psychiatric intervention that would best further these interests. There appears to be a widespread perception amongst psychiatrists that once a coercive intervention is adjudged by them to be in the best interests of a subject, no further substantive bar exists to implementing that intervention.

The unwillingness of the courts – and of philosophers of psychiatry – to fully confront the gravity and extent of coercive psychiatric practices was noted in an earlier subsection but such unwillingness also extends to psychiatry⁵⁸ where the concept of

⁵⁷ Fulford (1989), p.188-9.

The reliance on intuition rather than explicit justification is all the more surprising in that the psychiatric definition of delusion is, in essence, a belief which he who professes the belief, is unable to justify.

⁵⁸ See Thornicroft (2006), p.154: “*Involuntary commitment is rarely acknowledged by professionals to be one fundamental element underlying mental health services.*”

‘coercion’ is so underexplored in both research literature and textbooks (and its extent so minimised) as to merit the description ‘denial’.⁵⁹ A search, for example, of the journal *The New England Journal of Medicine* for occurrences of both ‘coercion’ and ‘psychiatry’ in the text of any article published between September 1993 and September 2009, yielded 5 results only 3 of which addressed coercive psychiatry and these were book reviews.⁶⁰ A search of the journal *Philosophy, Psychiatry, & Psychology* between March 1993 and September 2009, for ‘coercion’ in the ‘subjects’ field retrieved no results and in ‘full text’ retrieved 49 results which - with the exception of an article by Szasz, various responses to him and reviews of his work - yielded little of direct relevance.⁶¹

Szasz – as may have been gleaned from the nature of the references to him by Hansen and Fulford (*supra*) – is something of a *bête noire* to many of his professional colleagues; he has been an unrelenting critic not only of the use of coercion in psychiatry but of the psychiatric ‘project’ itself as it is commonly understood – indeed he has argued that coercion is intrinsic to psychiatry:

Psychiatry and coercion are like conjoined twins sharing a single heart: they cannot be separated without killing at least one. Coercion (the use of force) is here to stay. The impulse to use force is reflexive; it can be domesticated, but it cannot be destroyed.⁶²

The position for which I argue is different to and considerably less extreme than Szasz’s and will be set forth in the dissertation conclusions but his main relevance at this juncture is to permit the nature of the reaction of the psychiatric profession to his views⁶³ – especially in relation to his criticism of the use, and extent, of coercion in psychiatry – to be more clearly seen.

⁵⁹ Though, amongst others, Beattie (2009), Swanson (2003), Van Dorn (2006) and Large (2008) manifest, to varying degrees, a somewhat sceptical attitude to the benefits of using coercion in psychiatry as do Priebe (2009) Priebe (2010), LeBel (2011a), LeBel (2011b), and Newton-Howes & Mullen (2011) which are discussed in Chapter 7.

See also Oaks (2011) who reports on a conference held in Dresden in 2007 under the auspices of the World Psychiatric Association on the topic of coercion in psychiatry; one result of this conference was the publication of an edited collection of articles [Kallert (2011)], Oaks (2011) being one such article. Oaks – who describes himself as a ‘psychiatric survivor’ – though initially optimistic, has seen little progress in perspectives such as his being given an audience by mainstream psychiatry.

⁶⁰ Searches for either “forcible medication” AND psychiatry’ or “forced treatment” AND psychiatry’ yielded no results. [Searches conducted on 11 September 2009.]

⁶¹ Search conducted on 11 September 2009.

⁶² Schaler (2004), p.53.

⁶³ These reactions ranged from when, as a Professor of Psychiatry, he was banned from teaching as a result of having published *The Myth of Mental Illness*; to calls to the American Psychiatric Association for him to be disciplined for voicing his criticism of psychiatry outside of professional circles. [Szasz (2010), p.229].

Schaler (2004) – which consists of articles by some of Szasz’s critics with Szasz responding to each in turn – contains two particularly egregious examples of the professional ‘denial’ of the extent of psychiatric coercion.

The first occurs in an article by E. James Lieberman⁶⁴ who writes: “*One rarely hears of someone being committed involuntarily to a mental hospital, and Szasz provides no statistics.*”⁶⁵

Szasz responds:

This an astounding assertion. Not a day passes without the media reporting that this or that person has been detained for ‘psychiatric evaluation’. ... I suppose that in 1842, a comfortable, upper-middle class American rarely heard of a slave being mistreated, ...⁶⁶

As to statistics, Szasz cites references in rebuttal and states:

According to the latest statistics, “*Each year in the United States well over one million persons are civilly committed to hospitals for psychiatric treatment. ... It is difficult to completely separate discussions of voluntary and involuntary commitment because voluntary status can be converted efficiently to involuntary status, once the patient has requested release.*”⁶⁷

The second example is a contribution by Rita Simon⁶⁸ who speaks of “*a few individuals*”:

... who cannot be held accountable. A mental disability or disease deprives them of even the minimal capacity for rational and voluntary choices on which the law’s expectation of responsibility is predicated. ... For these few ... social control may be best served by confinement in a secure hospital setting especially in the case of those who are dangerously insane.⁶⁹

As part of an extensive rebuttal of Simon, Szasz comments:

I regard an institution in which an individual is incarcerated, often for decades or for life, as a prison, even if it is called a ‘hospital setting.’ Simon does not address this issue.⁷⁰

Denial in relation to coercive psychiatry features not only in relation to the extent of coercive practices but also to the locus of responsibility for their use; Pies (2004), for example, argues that: “... *involuntarily hospitalization is not intrinsically a function of psychiatric diagnosis.*”⁷¹ and quoted with approval a legal textbook which argued that:

⁶⁴ Professor Lieberman is Clinical Professor of Psychiatry at the George Washington University.

⁶⁵ Lieberman (2004), p.229.

⁶⁶ Szasz (2004a), p.242-244.

⁶⁷ *Ibid.* p.243; [References omitted].

⁶⁸ Professor Simon is University Professor, Department of Justice, Law and Society at American University in Washington.

⁶⁹ Simon (2004), p.200.

⁷⁰ Szasz (2004b), p.203.

⁷¹ Pies (2004), p.343. Ronald Pies is Clinical Professor of Psychiatry at Tufts University. [Emphasis in original].

... mental health professionals must understand that it is not they who make commitment decisions about patients. Commitment is a judicial decision that is made by the court ...⁷² [Emphasis in original]

D.2: Some dissident voices from within the psychiatry

The goal of this subsection is to show that criticisms of various aspects of psychiatric practice which will be made in later chapters, are not the criticisms of a maverick contrarian but have also been made by eminent academic psychiatrists some of whom are highly critical of the direction taken by modern psychiatry. The views of these 'dissident' psychiatrists are culled from later chapters of this dissertation where their context is clarified; they are quoted here without further comment. They are broadly categorised under the headings 'General' [D.2.1], 'Diagnosis' [D.2.2], 'Treatment' [D.2.3] and 'Assessment of Dangerousness' [D.2.4].

D.2.1: General

Example 1: Such lack of attention to logic and critical thinking in psychiatry may be found even at the very core of clinical psychiatric practice. ... Does a psychiatrist always know what is a good or bad argument?⁷³

Example 2: "Rationality" and "irrationality" are among the most important concepts in both psychiatry and philosophy. Yet psychiatrists have generally not presented any explicit account of them and have often not distinguished these concepts from related ones like "mental health" and "mental illness."⁷⁴

Example 3: ... American psychiatrists rarely study mentally healthy people. ... Psychiatry lacks a conception of healthy mental life; *i.e.*, it lacks an understanding of psychological normalcy. As a result, most aspects of patients' lives are perceived in pathological terms. ... By default, then, mental health comes to mean social conformity.⁷⁵

Example 4: Most psychiatrists with whom I've talked agree in principle with the approaches for which there is an evidence base, but few actually use them or prescribe their use. ... We do not ensure quality in our own ranks. Our system of self-discipline is erratic, inconsistent, and also not in the public interest. We allow an unacceptable rate of medical errors in our practice, even as we campaign for tort reform. We have let the biopsychosocial model become the bio-bio-bio model.⁷⁶

Example 5: The whole picture (on the provision of care and treatment) is distorted by the use or prospect of compulsion, which deters people from seeking treatment,

⁷² *Ibid.*, p.341.

⁷³ Professor Milos Jenicek in his opening address to a conference on 'Evidence Based Psychiatry' [Jenicek (2003)].

⁷⁴ Culver & Gert (1982). *Philosophy in Medicine: Conceptual and Ethical Issues in Medicine and Psychiatry*, p.20.

⁷⁵ Wiggins & Schwartz (1999). Dr. Schwartz is professor of psychiatry at Case Western Reserve University. Dr. Wiggins is professor of philosophy at the University of Louisville. Both are founding members of the Association for the Advancement of Philosophy and Psychiatry.

⁷⁶ Sharfstein (2006), p.3. Steven Sharfstein is a Past President of the American Psychiatric Association.

denies them the right to choose the treatment they want, and prioritises certain kinds of patient in the offer of services.⁷⁷

D.2.2: Diagnosis

Example 6: [Describing the meeting of a DSM–III diagnostic subcommittee] ... criteria, and even whole diagnoses, were created or dispensed within a session that involved a small group seated around a computer terminal. ... “one criterion was dropped because a workgroup member piped up with ‘I do that sometimes.’”⁷⁸

Example 7: [Reading the draft DSM–V] ... is to see the discipline's floundering writ large. Psychiatry seems to have lost its way in a forest of poorly verified diagnoses and ineffectual medications. Patients who seek psychiatric help today for mood disorders stand a good chance of being diagnosed with a disease that doesn't exist and treated with a medication little more effective than a placebo.⁷⁹

Example 8: [In discussing the draft DSM–V] The suggested subthreshold and premorbid diagnoses ... could add tens of millions of newly diagnosed “patients” – the majority of whom would likely be false positives subjected to the needless side effects and expense of treatment. ... it has been insensitive to the great risks of false positives, of medicalizing normality, and of trivializing the whole concept of psychiatric diagnosis.⁸⁰

Example 9: It is my belief that the full picture of schizophrenia is, to a considerable degree, iatrogenic; that is, it is partially created by the psychiatric intervention itself, establishing a pathway of illness behaviour extending over weeks or months, with heavy medication and institutionalisation. Thus, the young person loses connection with ordinary living at a critical time and finds it difficult to reintegrate back into society. It is only then that the full picture of the illness we call schizophrenia supervenes.⁸¹

Example 10: Despite diagnosing schizophrenia in similar proportions of patients, the Jamaican psychiatrist and British psychiatrists showed low levels of agreement on *which* patients had this illness. ... There was agreement on the diagnosis for 16 (55%) of these patients, and disagreement on the diagnosis for the other 13 (45%).⁸²

D.2.3: Treatment

Example 11: A series of pivotal effectiveness studies, in psychiatry—STAR*D, CATIE, and STEP.BD—have compared real-world performance of various treatments in depression, schizophrenia, and bipolar disorder. STAR*D showed that virtually all antidepressant strategies had low and similar efficacy in major depression. CATIE showed low effectiveness and similar comparability of

⁷⁷ Royal College Of Psychiatrists (2004), p.1, in a submission to the (UK) Joint Committee on a draft Mental Health Bill.

⁷⁸ Ritchie (1989), p.698. Karen Ritchie was formerly Chief of Psychiatry at the University of Texas.

⁷⁹ Shorter (2010). Edward Shorter is Professor of the History of Medicine and Psychiatry at the University of Toronto.

⁸⁰ Frances & Spitzer (2009). Robert Spitzer was an editor of both the DSM-III and DSM-IV; Allen Frances was the chairman of the DSM-IV Task Force.

⁸¹ Browne (2008), pp.258-9. Ivor Browne was Professor of Psychiatry at University College, Dublin and Chief Psychiatrist to the Eastern Health Board.

⁸² Hickling (1999), p 284. [Emphasis in original]. Frederick Hickling is Professor of Psychiatry at The University of the West Indies, Jamaica.

antipsychotics. And STEP.BD showed that antidepressants are not effective for bipolar depression.⁸³

Example 12: [Discussing the CATIE study] The most stunning finding was that psychiatrists tend to ignore life-threatening, treatable medical conditions in patients presenting for treatment with schizophrenia. Of patients entering the study, 45% had untreated diabetes, 89% had untreated hyperlipidemias and 62% had untreated hypertension. ... [CATIE] did expose a woeful standard in the medical management of schizophrenia offered by psychiatrists.⁸⁴

Example 13: The list of problems with the DSM-IV is well known. They include the significant degree of comorbidity among patients, the related problem of poor separation among DSM-IV disorders ... as well as the poor separation of disorder from normality, the dramatic non-specificity of pharmacologic agents in treating the various disorders ... our current practice of using just about every class of psychotropic to treat just about every class of disorder.⁸⁵

Example 14: [Discussing research findings on atypical antipsychotics] ... what was seen as an advance 20 years ago ... is now, and only now, seen as a chimera that has passed spectacularly before our eyes before disappearing and leaving puzzlement and many questions in its wake. ... The spurious invention of the atypicals can now be regarded as invention only, cleverly manipulated by the drug industry for marketing purposes and only now being exposed. ... But how is it that for nearly two decades we have ... 'been beguiled' into thinking they were superior?⁸⁶

Example 15: [Discussing the use of antipsychotics in the treatment of the elderly] As clinicians we talk about "*the best interests of our patients*". How can a treatment which doubles the rate of cognitive decline, triples the rate of stroke, doubles mortality, substantially increases falls and fractures and reduces quality of life be beneficial, ...⁸⁷

Example 16: According to the published literature, it appeared that 94% of the [antidepressant] trials conducted were positive. By contrast, the FDA analysis showed that 51% were positive.⁸⁸

D.2.4: Assessment of Dangerousness

Example 17: Predictions which can be employed to guide decisions and actions are difficult when the base rate for the event to be predicted is low. To take a hypothetical example: if the annual rate of serious violence in a community is 20 per 100,000, then with a predictor with a specificity and sensitivity of 95% for a society the size of New Zealand (3 million), you will be able to prevent in each year 570 assaults, will miss 30, but the price will be confining 150,000 innocent Kiwis.⁸⁹

Example 18: ... predictions of violence are highly subjective and seem at best unreliable and at worst "*imprecise ... and perhaps fruitless.*"..... unreliable assessments of dangerousness of patients compromises the profession's position of acting beneficently, ... accusations of maleficent outcome are difficult to defend.

⁸³ Parikh (2009). S.V. Parikh is of Department of Psychiatry, University of Toronto.

⁸⁴ Bick (2007), p.465.

⁸⁵ Phillips (2010), p.10. Sidney Phillips is Clinical Professor of Psychiatry at Yale.

⁸⁶ Tyrer & Kendall (2009), p.4. Tyrer & Kendall (2009) was an editorial in *The Lancet*.

⁸⁷ Ballard (2005). Clive Ballard is Professor of Old Age Psychiatry at the University of Newcastle.

⁸⁸ Turner (2008), p.252. Erick Turner is a former clinical reviewer of psychotropic drugs at the FDA.

⁸⁹ Mullen (1984), p.10. P.E. Mullen is Professor of Forensic Psychiatry, Monash University.

The maxim “*above all do no harm*” has been ignored in the case of patients who are condemned to a limbo existence on crowded wards ...⁹⁰

Section E: Crossing the disciplinary threshold

Is it necessary to cross the disciplinary threshold?

At the start of this Introduction it was suggested that in order not to prejudge an ethical investigation of coercive psychiatric practices, the terms ‘diagnosis’ and ‘treatment’ should – at least mentally – be replaced by terms such as ‘how some people are picked out’ and how, having been chosen, ‘things are done to them.’

The adoption of such a terminology would clearly indicate that the disciplinary boundaries of philosophy and psychiatry must be crossed to enable the field of investigation to become not only what psychiatrists say they do, but what they actually do. To argue otherwise would necessitate accepting at face value the account of coercive psychiatry as told by the generality⁹¹ of psychiatrists and would mean implicitly accepting psychiatric diagnostic practices, treatments and assessments of dangerousness as being essentially unproblematic.⁹²

The seeming certainty of an assertion by a psychiatrist that a subject should be detained and forcibly treated on, say, the grounds of his dangerousness to others, would suddenly evaporate if a not insubstantial possibility of error is found to exist. A refusal to acknowledge the relevance of, for example, the Report of the National Council on Disability (*supra*) or the opinions of psychiatrists who dissent from the views of their more mainstream colleagues, to an ethical investigation of coercive psychiatry, would not only eviscerate any such scrutiny but would, I suggest, render it a deeply unethical exercise.⁹³

⁹⁰ Welsh & Deahl (2002), p.254. Welsh & Deahl (2002) is an article on psychiatric ethics. Susan Welsh is a Specialist Registrar in Old Age Psychiatry; Martin Deahl is a Consultant Psychiatrist at St Bartholomew's Hospital, London.

⁹¹ Though such an assessment is subjective, the justification for using it and other terms such ‘mainstream’ – and, conversely, the term ‘dissident’ – will become clear on a reading of the main chapters of this dissertation.

⁹² And that on the (presumably rare) occasions when they are problematical, their resolution lies solely within the jurisdiction of the psychiatric profession. See, for example, Brakel (2010):

If that is considered a problem by psychiatry, it is up to psychiatry to try to come up with the remedy. It should not look to the law or the courts, let alone the United States Supreme Court, to do the profession's dirty work (if it is that).

Samuel Brakel is Professor of Law at DePaul University, Chicago; the question might well be posed as to whether Professor Brakel would apply the same reasoning to other professions – such as tax accountants – whose practices might be more likely to have a direct impact on individuals such as professors of law.

⁹³ In that it would purport to be that which it is not (unless, of course, its provisional and tentative nature was obvious.).

My MPhil dissertation⁹⁴ raised similar problems and – in that the conceptual scheme used there is the progenitor of the one to be used in this dissertation – may be of some interest at this point. The dissertation was an examination of the ethical grounds on which end-of-life decisions were made in relation to patients diagnosed as being in a Persistent Vegetative State [PVS]; the generality of medical opinion being that this condition offered no hope of recovery and that such patients lacked consciousness and, in particular, the ability to experience pain. Ethical and legal discussion of such cases seldom looked behind this medical consensus. On examination of the medical research findings, however, a high rate of misdiagnosis was found to exist,⁹⁵ with some patients recovering and reporting that they had been conscious at a time when their medical carers adjudged them to have lacked consciousness. An ethical examination of this revised problem was considerably more complex than the problem as originally stated; furthermore (to echo the earlier point) a refusal to cross the disciplinary boundary to examine, for example, rates of misdiagnosis, resulted in a deeply misleading formulation of the underlying ethical problem such as to render any resulting ethical analysis into something resembling a charade.

The conceptual scheme used in discussing the PVS problem relied on two pillars: an analysis of euthanasia by Philippa Foot⁹⁶ and the use of a stipulative definition of personhood. The same two pillars will be used in the formulation of this dissertation argument and will be discussed in Section F *infra*.

Before leaving this discussion on the appropriateness of crossing disciplinary boundaries, it is noteworthy that one of the most influential philosophical critiques of psychiatry⁹⁷ was by a philosopher – Foucault – who not only was not a respecter of the traditional disciplinary boundaries, but whose philosophical analysis drew its power out of that very fact.⁹⁸

⁹⁴ Roche (2000). *An alternative conceptual structure for the resolution of 'end-of-life' problems involving PVS patients*. MPhil thesis. University College, Cork.

⁹⁵ Andrews (1996), for example, reported a misdiagnosis rate of 43%.

⁹⁶ Foot (1977).

⁹⁷ Gutting (2005a) (p.49), quotes Roy Porter: “*Time has proved Madness and Civilization far the most penetrating work ever written on the history of madness.*”

⁹⁸ See, for example, Gutting (2005), p.4:

General interpretations of Foucault suppress his marginality by presenting his work as the solution to the problems of an established discipline or as the initiation of some new discipline. This ignores the crucial fact that disciplines are precisely the dangers from which Foucault is trying to help us save ourselves. His attacks are on the apparently necessary presuppositions (such as that madness is mental illness, ...) that define disciplines. Therefore, they can be launched only from the peripheral areas where the defining assumptions begin to lose hold.

To present Foucault as working within an established discipline or, even worse, as attempting to found one himself is to contradict the basic thrust of his efforts.

One consequence of widening the investigation to include aspects of psychiatric practice is that it becomes imperative that the discussion be tightly focussed; this entails that the analysis of some concepts – such as personhood – which would normally receive a much more thorough discussion if a purely philosophical approach were adopted, will necessarily be curtailed.

Who may cross the disciplinary threshold?

At first glance it might seem that professional qualifications in both philosophy and psychiatry would be the most desirable attributes in one seeking to scrutinize the ethical justifications for coercive psychiatry; however, as discussed in Chapter 4,⁹⁹ an ethic of collegiality often exists between members of a professional group which results in at least a ‘blunting’ of criticism of the profession or of professional colleagues.¹⁰⁰

Professor Fulford, for example, in his discussion of the ethical justification for coercive psychiatric treatment (*supra*) may be thought to have allowed his psychiatric *persona* to overwhelm his philosophical analysis.

Foucault, though preeminent amongst philosophers of psychiatry, was not a psychiatrist indeed he manifested a degree of antipathy towards that profession:

Foucault refers to the “*malaise*” and the “*great personal discomfort*” that resulted from his experience of working at Sainte-Anne. The situation appears to have centered on Roger, a patient of Foucault’s, who was subjected to the ultimate act of therapeutic despair, namely, a prefrontal lobotomy, ... Not only does it seem to have derailed Foucault’s plans to become a psychiatrist, but it also seems to have left him with an “*indelible image of suffering*.”¹⁰¹

The fact that Foucault adopted a critical stance towards psychiatry was perhaps due to his personal history and temperament more than to his training as a philosopher.

However, the discipline of Philosophy – though perhaps preeminent – is not alone in fostering a degree of scepticism towards the sacred icons of the wider world; Law is another such discipline. Gunnar Olofsson,¹⁰² a sociologist, has written on the problems that arise in professions which have been essentially exempt from independent oversight; he speaks of the “*dark side*” of such professions – *i.e.* those deeply problematic areas which are well recognised from within the professions but which are not publicly acknowledged. He considers the use of lobotomy to be an example of the dark side of psychiatry; Kingdon’s (2004) finding¹⁰³ that UK psychiatrists considered

⁹⁹ Where the terms ‘*confirmation bias*’, ‘*informational cascades*’, ‘*groupthink*’ and ‘*herding*’ are discussed.

¹⁰⁰ Witztum (1995b), for example, has discussed the reluctance of psychiatrists to overturn a diagnosis made by a colleague. [See Chapter 4].

¹⁰¹ Whitebook (2005), p.317.

¹⁰² Gunnar Olofsson, School of Social Sciences, University of Växjö, Sweden.

¹⁰³ Kingdon (2004), p.402.

the misdiagnosis of schizophrenia¹⁰⁴ by other psychiatrists to be “*common*”, is perhaps another. Olofsson’s (2007) conclusion was that:

The most effective countervailing power to the medical profession was not politicians or administrators, but representatives of another profession, in the [*sic*] case the law ... This finding thus points to the key role of professions balancing and controlling each other.¹⁰⁵

A legal training is designed to permit a practitioner to quickly get to the heart of contentious issues which may well depend on highly technical matters of which he may have had no previous experience.¹⁰⁶ He must accomplish this to a degree sufficient to enable him to cross-examine a possibly hostile witness on matters concerning which the witness has a generally accepted expertise. Medical negligence actions are obvious examples and the Manweiler case is one such from psychiatry. In this case Manweiler’s counsel subjected the Chief Psychiatrist of a Dublin hospital to a strenuous cross-examination in which he argued that not only had the psychiatrist given the wrong diagnosis but also prescribed an inappropriate treatment and, in addition, made an erroneous assessment of dangerousness. The fact that the jury awarded not only substantial but exemplary damages to Manweiler, is testimony to the ability of lawyers to subject clinical psychiatric practices to a critical scrutiny.

Section F: Towards an outline of the dissertation argument

The supposed dangerousness of the mentally ill is often cited (especially in the popular media) as providing an adequate justification for coercive psychiatric interventions. Yet despite the facts that

- the evidence in support of any such link is tenuous¹⁰⁷ and
- the ability of psychiatrists to predict violence is poor,¹⁰⁸

this, presumed, dangerousness exercises a disproportionate influence on debates concerning involuntary committal and treatment. To obviate the risk of this occurring, I propose to structure the argument into three stages:

¹⁰⁴ Amongst black subjects.

¹⁰⁵ *Op. cit.*, p.11.

¹⁰⁶ See, for example, Judge Declan Costello who (on the basis of his report into the Whiddy Island shipping disaster) was presented with an award by the Association of Consulting Engineers for his “*outstanding contribution to engineering understanding by a non-engineer*”. See *The Irish Times*. (2011). ‘Former High Court president ‘one of the finest minds’ the country has had’. *The Irish Times*, 7 June.

¹⁰⁷ See Chapter 6.

¹⁰⁸ For example, Szmulker (2001) who in his criticism of a paper by Dolan & Doyle (2000) (which had reviewed the current status of violence risk prediction research) pointed out that it had omitted all discussion of ‘false positives’ and that the test which they had endorsed would, in the most common circumstances “... *be wrong almost nine times out of ten*”.

George Szmulker is Dean of the Institute of Psychiatry at King’s College, London.

- Stage 1: examines coercive psychiatric interventions undertaken solely in the interests of the subject;
- Stage 2: examines coercive psychiatric interventions undertaken solely in the interests of others;
- Stage 3: examines coercive psychiatric interventions undertaken on mixed grounds – *i.e.* both in the interests of the subject and in the interests of others.

Such a separation of the argument into distinct strands is also of importance for reasons of philosophical clarity especially as proffered justifications for a coercive psychiatric intervention are often based on a conflation of supposed best interests considerations and unexamined, prejudicial presumptions as to dangerousness;¹⁰⁹ it is important that such questions – and, in any particular case, the supporting evidence – be independently subjected to rigorous scrutiny.

The essential core of the argument will be developed in Stage 1 and this will be the focus of the remainder of this outline and of the succeeding chapters. The Stage 2 argument will be addressed in Chapters 6 and the Stage 3 argument, in the dissertation conclusions.

F.1: Foot's argument concerning euthanasia

F.1.1: Foot's (1978) argument

To Foot, “*an act of euthanasia as here understood is one whose purpose is to benefit the one who dies.*”¹¹⁰ It is undertaken “*for his sake*”¹¹¹ and “*as a good for the one who dies*”¹¹²; more colloquially, it is undertaken in the ‘*best interests*’ of the one who dies. Foot then turns to the question of how someone’s death might be considered to be ‘a good’ for them (a discussion which is of no relevance in the present context); she then examines the circumstances under which euthanasia might be justified. In this, she eschews the more usual analysis based on the act/omission distinction and argues:

It is not that killing is worse than allowing to die, but that the two are contrary to distinct virtues, which gives the possibility that in some circumstances one is impermissible and the other permissible.¹¹³

This brings us to the core of Foot’s analysis which is her discussion of the virtues of justice and charity and to their differing – and sometimes conflicting – obligations. “*An*

¹⁰⁹ See, for example, *Gooden v St. Otteran's Hospital* (2005) *supra*. The jurist Saleem Shah has criticised the US courts for similarly conflating these issues. [See Shah (1977), p.94]

¹¹⁰ Foot (1977), p.108.

¹¹¹ *Ibid.* p.86.

¹¹² *Ibid.*

¹¹³ *Ibid.* p.101. [Emphasis in original].

*unjustified act of killing, or allowing to die, is contrary to justice or to charity, or to both virtues, and the moral failings are distinct.”*¹¹⁴

Justice, she states:

... has to do with what men *owe* each other in the way of noninterference and positive service. When used in this wide sense, which has its history in the doctrine of the cardinal virtues, justice is not especially connected with, for instance, law courts ... Justice as such is not directly linked to the good of another, and may require that something be rendered to him even where it will do him harm, as Hume pointed out when he remarked that a debt must be paid even to a profligate debauchee who "*would rather receive harm than benefit from large possessions*".¹¹⁵

Charity, on the other hand:

... is the virtue which attaches us to the good of others. An act of charity is in question only where something is not demanded by justice, but a lack of charity and of justice can be shown where a man is denied something which he both needs and has a right to;¹¹⁶

To Foot, the distinction between charity and justice is "*of the first importance*"¹¹⁷

principally because of the connection between justice and rights of which she says:

I believe it is true to say that wherever a man acts unjustly he has infringed a right, since justice has to do with whatever a man is owed, and whatever he is owed is his as a matter of right.¹¹⁸

Foot then turns to a discussion of differing kinds of rights and distinguishes between right as '*liberty*'¹¹⁹; as '*claim-right*'¹²⁰ and as '*claim*'¹²¹. Foot describes 'the right to life' as including certain liberties but, more importantly the: "... *cluster of claim-rights* ... *The chief of these is, of course, the right to be free from interferences that threaten life.*"¹²²

¹¹⁴ *Ibid.* p.97.

¹¹⁵ *Ibid.* p.97. [Emphasis in original]

¹¹⁶ *Ibid.* p.97.

¹¹⁷ *Ibid.* p.97.

¹¹⁸ *Ibid.* p.97.

¹¹⁹ *Ibid.* p.98: "... *that no one can demand that he do not do the thing which he has a right to do*"¹¹⁹ e.g. he has the liberty to park his car in a public car park.

¹²⁰ *Ibid.* p.98. "*Claim rights generate duties; sometimes these duties are duties of noninterference; sometimes they are duties of service.*" e.g. he has the right to park his car in his own car-park; others are under a duty not to interfere with his exercise of this right.

¹²¹ In explanation, Foot [*ibid.* p.99] quotes Feinberg who speaks of: "... *the manifesto writers... what they call "human rights," are more properly described ... as claims.*" [Emphasis in original]

¹²² *Ibid.* p.99. This quotation might seem to imply that "*the right to be left alone*" of which Foot speaks, relates only to the right not to be killed; this is not so. The quotation appears in the context of a discussion on euthanasia and hence its specificity; the right of which Foot speaks is, she argues, a right of "*noninterference*" (*supra*) conferred by Justice on *all* persons.

The example of the wounded soldier (see F.1.3 *supra*) used by Foot in setting forth her argument has as an implicit analogy the case of an individual coming across an animal who was mortally wounded and in great distress. Whilst the individual may be under a moral obligation under Charity to put the animal 'out of its misery'; no such obligation exists in relation to persons; on the contrary, argues Foot, Justice obliges us to respect the right of any such person to refuse any proffered assistance irrespective of how compelling the intuition might be that the assistance be in the person's 'best interests'.

N.B.: As is evident from Foot's discussion of vegetative state patients,¹²³ the life which must not be threatened is not simply human life but is rather the right to live an autonomous life, free from the interference of others; in this she implicitly distinguishes between 'humans' and 'persons'.

Based on her analysis, Foot concludes:

- firstly, that the right to life confers "*the right to be left alone*"¹²⁴.
- secondly, that in judging the correctness of interfering in the life of another, justice must always prevail over charity.

In relation to this second point she says: "*It is important to emphasize that a man's rights may stand between us and the action we would dearly like to take for his sake.*"¹²⁵ and again:

Nevertheless, a man may have the right to something which he himself would be better off without; where rights exist it is a man's will that counts not his or anyone else's estimate of benefit or harm. So the duties complementary to the right to life the general duty of noninterference and the duty of service incurred by certain persons – are not affected by the quality of a man's life or by his prospects. Even if it is true that he would be, as we say, "*better off dead*," so long as he wants to live this does not justify us in killing him and may not justify us in deliberately allowing him to die. All of us have the duty of noninterference.¹²⁶

Armed with this conclusion Foot then returns to her discussion of euthanasia:

But as we so defined an act of euthanasia that it seeks a man's death for his own sake – for his good – charity will normally speak in favor of it. This is not, of course, to say that charity can require an act of euthanasia which justice forbids, but if an act of euthanasia is not contrary to justice – that is, it does not infringe rights – charity will rather be in its favor than against.¹²⁷

The completion of her argument is of no further relevance to the dissertation argument; however some points which are subsidiary to her main argument, have some relevance.

Our primary obligation to persons, argues Foot, is that we respect their "... *right to be let free from unwanted interference*". It is by virtue of the existence of this obligation that the ethical obligations due to persons are distinguished from those due to animals.

¹²³ *Ibid.* p.111:

... like Karen Ann Quinlan, in a state of permanent coma. Much could be said about this last case. It might even be suggested that in the case of unconsciousness this "life" is not the life to which "the right to life" refers. But that is not our topic here.

¹²⁴ *Ibid.* p.100.

¹²⁵ *Ibid.* p.102.

¹²⁶ *Ibid.* p.100.

¹²⁷ *Ibid.* p.106.

F.1.2: Foot (1978): some points concerning ‘best interests’

‘Best interests’ – is intention sufficient?

Foot asks whether, when someone acts in the best interests of another: “... *is it enough that he acts with this thought, or must things actually be as he thinks them to be?*”¹²⁸ Foot’s response is that however we answer this question “... *culpability or justifiability will be the same: if a man acts through ignorance his ignorance may be culpable or it may not.*”¹²⁹

The conclusion is clear: when an intervention causes harm the fact that the harm was not intended or even that the intention was ‘to do good’, is not necessarily a defence. Thus a psychiatrist’s actual knowledge of the likelihood of psychiatric misdiagnosis and iatrogenic harm (as judged against then known research findings) is relevant in discussing the justification for a coercive intervention.

‘Best interests’ – the need to proclaim all interests

Foot notes that often when an action is proclaimed to be in a subject’s best interests, it may in reality be serving other interests:

The fact is, of course, that the doctors who recommend against life-saving procedures for handicapped infants are usually thinking not of them but rather of their parents ... or of the "burden on society" if the children survive. So it is not for their sake but to avoid trouble to others that they are allowed to die. When brought out into the open this seems unacceptable.¹³⁰

Likewise a degree of scepticism may be appropriate when it is asserted that a coercive psychiatric intervention is being undertaken solely in the best interests of the subject.

‘Best interests’ – the accommodation of the rights of others

Foot acknowledges that her analysis may be complicated by the rights of others:

However, there are circumstances, even if these are very rare, in which one man's life would justifiably be sacrificed to save others, and "killing" would be the only description of what was being done. For instance, a vehicle which had gone out of control might be steered from a path on which it would kill more than one man to a path on which it would kill one.¹³¹

The underlying principle would appear to be that the competing rights – the rights to be sacrificed vs. the rights to be respected – must be of a comparable level of importance. This point has relevance to Stages 2 and 3 of the dissertation argument where coercive psychiatric intervention on the grounds of dangerousness to others is incorporated into

¹²⁸ *Ibid.* p.87.

¹²⁹ *Ibid.* p.87.

¹³⁰ *Ibid.* p.109.

¹³¹ *Ibid.* p.102.

the main argument and would suggest that the (probable) consequences of non-intervention must manifestly outweigh the loss of liberty consequent on incarceration.

F.1.3: Relevance of Foot's main argument to the dissertation argument

Foot, in setting out her argument, posed a problem:

Suppose, for example, that a retreating army has to leave behind wounded or exhausted soldiers in the wastes of an arid or snowbound land where the only prospect is death by starvation or at the hands of an enemy notoriously cruel. It has often been the practice to accord a merciful bullet to men in such desperate straits. But suppose that one of them demands that he should be left alive? ... The right to life can sometimes give a duty of positive service, but does not do so here. What it does give is the right to be left alone.¹³²

Her analysis of the respective roles of justice and charity leads her to the conclusion that, in relation to any individual subject, the demands of justice (and the right of non-interference that it entails) takes precedence over the demands of charity and "... *the action we would dearly like to take for his sake.*"¹³³

From this it may be concluded that a coercive psychiatric intervention even if clearly in the best interests of the subject, requires a level of *additional* justification sufficient to warrant the abrogation of the subject's rights; furthermore the level of intervention – whether by the sustained use of a medication having the effect of trespassing deeply on the subject's sense of self or by virtue of the duration of the intervention – may be such as to '*effectively destroy*'¹³⁴ the subject's right to life in the sense of his own life lived according to his own lights¹³⁵ and, if so, would require the most compelling and sustained justification.

F.2: Personhood: Some perspectives and distinctions

F.2.1: Various meanings of the term 'personhood'

I wish to distinguish a number of contexts where the term 'personhood' will be used in this dissertation; four senses of the term will be identified,¹³⁶ each with its associated 'rights-cluster'. Though the distinctions are somewhat artificial, they are being used to highlight aspects of a more general concept of personhood which, for ease of analysis, are being regarded as separable.

¹³² *Ibid.* p.48.

¹³³ *Ibid.* p.102.

¹³⁴ The usage of the terms 'damaged', 'destroyed' and 'effectively destroyed' in the context of personhood, is discussed in the following subsection.

¹³⁵ *Ibid.* p.100.

¹³⁶ Doubtlessly other contexts can be identified but these are sufficient for discussion of the dissertation argument.

Personhood in the context of Ethical Theory [Personhood_{ETH}]

Personhood_{ETH} indicates that personhood is being discussed in an ethical or philosophical context and, correspondingly, ‘Rights-Cluster_{ETH}’ denotes that set of rights, as uncovered by ethical or philosophical analysis, which are deemed intrinsic to being a ‘person’. This is the sense in which Foot uses the term.

Personhood in the context of Political Theory [Personhood_{POL}]

The term Personhood_{POL} is used in relation to a specific political culture and refers to the ideological criteria required for the recognition of an individual as a person and for owning a particular ‘Rights-Cluster_{POL}’.

In modern western democracies the concept of person and the associated rights-cluster specified by modern theories of ethics, generally coincide with those specified by modern political theory. In particular, western democracies subscribe to the view that all persons have equal claim to the particular ‘rights-cluster’ associated with personhood.

Personhood in the context of Sociology [Personhood_{SOC}]

The term Personhood_{SOC} is used in relation to a specific society and refers to how the particular ‘Rights-Cluster’ deemed characteristic of personhood in that society, varies between different social groups; for example, in contrast to those who are native born, illegal immigrants may – in extreme cases – be regarded by society as outcasts or ‘non-persons’.

In the context of Personhood_{SOC}, ‘Rights-Cluster_{SOC}’ corresponds to those ‘socially recognised rights’ as determined by population survey; Personhood_{POL}, in contrast, focuses on how a particular society describes itself to itself; the corresponding ‘rights-cluster’ being uncovered by means of a more theoretical analysis.

Alternatively, Personhood_{POL} implies the existence of certain rights (Rights-Cluster_{POL}); each of such rights – as do all rights – entails a correlative obligation on others to respect these rights. Personhood_{SOC} is the measure of how well these obligations are honoured when analysed across the society with particular reference to various subgroups.

The sociological context provides a means whereby the lived experiences of an individual or social group, in so far as it relates to their being treated by society generally ‘as a person’, may be discussed. Its use permits the concept of ‘stigma’ to be incorporated into the dissertation argument.

The relationship between Personhood_{ETH} and Personhood_{SOC} is such that Personhood_{ETH} provides the intellectual tools to enable the formulation of a critique of Personhood_{SOC}. Furthermore, whereas Personhood_{ETH} is an all-or-nothing concept [X is, or is not, a person], this is clearly not the case for Personhood_{SOC};¹³⁷ consequently, in such a context, it is possible to speak not only of the (effective) destruction but also of the ‘*diminishment*’ of personhood.

Personhood in the context of Law [Personhood_{LAW}]

The term Personhood_{LAW} is used in relation to a specific legal system and refers to an entity capable of owning legally enforceable rights [Rights-Cluster_{LAW}] as in the case of, for example, a limited company. Legal determinations as to personhood and rights may exert an influence on sociological determinations.

The term ‘justification’ is also open to a multiplicity of meanings depending on the context within which the act in question is sought to be ‘justified’. The term will only be used in the remainder of this dissertation in its philosophical sense.

F.2.2: Examples of the differing meanings of personhood

Example 1: Conjugal rights

In discussing the obligations of marriage, ethical theories of the mid 20th century sometimes spoke of the ‘conjugal rights’ of the man and the corresponding duties of the woman. From within such a perspective, the rights of a married, male person included conjugal rights; this meaning of personhood would be as Personhood_{ETH} and the conjugal rights would be part of Rights-Cluster_{ETH}.

The question might then arise (in relation to a particular nation or culture) as to whether such rights were, in theory, regarded as intrinsic to the culture; if so, they would be part of Rights-Cluster_{POL}.

It might also be asked whether in point of fact, these rights were widely regarded as valid within the culture or whether they were regarded as something of an anachronism and thus widely disregarded. If widely accepted, they would be part of Rights-Cluster_{SOC}.

Lastly, it might be asked as to whether the courts would assist in the enforcement of these rights, if so, they would be part of Rights-Cluster_{LAW}.

¹³⁷ That degrees of personhood_{SOC} exist is clear if one considers that, in respect of an individual being treated by his fellow beings ‘as a person’, no matter how badly he is treated, it can always be made worse.

Example 2: Right of lesbians to marry

A more topical example concerns the right of lesbian couples to marry. Used in this context, ‘right’ refers to Rights-Cluster_{ETH} in that those who advocate this right, claim that it flows from their concept of a person (Personhood_{ETH}).

By means of their advocacy they seek to have their claim accepted as part of the dominant ideology of the society; if they succeed, the right will be part of Rights-Cluster_{POL}.

However, even if they succeed, the broad mass of the population may not regard it as a valid right and, if so, it will not be part of Rights-Cluster_{SOC}.

They may also seek to have their claim legally recognised by the courts and if they succeed, it will then be part of Rights-Cluster_{LAW}.

Example 3: ‘Caste’ in India

The concept of person on which the constitution of India is based, recognises no difference in value between persons of different castes; the constitution itself and the legal system is egalitarian as is the professed ideology of India’s political class.

However, in India, caste and its associated rights are of considerable importance to everyday living. Thus whilst Personhood_{ETH}, Personhood_{POL} and Personhood_{LAW} are all blind as to caste, Personhood_{SOC} is alone in being able to provide a context for discussion of the lived experiences of an individual Indian in so far as it is related to their being treated as a ‘person’ or as a ‘non-person’ or ‘object’.

Example 4: Apartheid in South Africa

The situation in South Africa under apartheid provides an example of a context where not only Personhood_{SOC} but also Personhood_{ETH}, Personhood_{POL} and Personhood_{LAW} and their associated clusters of rights were all dependent on the race of the individual.

The failure to make distinctions between the various meaning of personhood can lead to considerable confusion as is shown by the following examples:

Example 5: Slaves as ‘persons’

Glantz (1983), writing about the role played by ‘personhood’ in US legal decisions, states:

The only time that United States courts and legislatures have broadly defined the outline of personhood has been in relationship to slavery. Kenneth Stampff ... argues that slaves were recognized as both “things” and “persons.” It is not at all clear what he means when he talks about slaves as persons. It is very clear what it means when slaves are seen as things ... In order to show that slaves were also deemed to be “persons”, Stampff points out that certain ... statutes required slave

owners to treat slaves with humanity – to provide necessary clothing and food

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...

In terms of the earlier terminology, slaves because they had a right, had Personhood_{LAW} but at the period in question they did not have Personhood_{ETH}, Personhood_{POL} or Personhood_{SOC}. Using but one term ‘person’ to cover all these disparate meaning is unhelpful.

Example 6: Animals as ‘persons’

Some academics have canvassed for the legal recognition of ‘animal rights’ however – as evidenced by a 2007 Austrian case¹³⁹ – one objection raised against awarding such recognition is that it would put humans and animals on the same level in that both would be considered to be persons. This difficulty immediately disappears once a more nuanced terminology is used: if the right or rights claimed for the animal are granted then the animal has Personhood_{LAW} but these rights pale in comparison to the Rights-Cluster_{ETH} associated with Personhood_{ETH} giving rise to no possibility of confusion.

F.2.3: A terminological clarification relating to personhood

F.2.3.1: The right to be let alone

In speaking of the ‘right to be let alone’ some clarification is necessary and the following two illustrations may assist.

Example 1: A victim of altitude sickness

The presence of what would normally be an innocuous instance of irrationality, can (if it occurs at an altitude of over 3,500 meters) be highly indicative of the onset of Acute Mountain Sickness (AMS) and – unless the individual is quickly brought to a lower altitude – cerebral or pulmonary oedema may result with a consequent high risk of fatality.¹⁴⁰ One likely consequence of such irrationality is that the climber will refuse to descend voluntarily and will have to be forced to do so.¹⁴¹ Could such a forced intervention be held to breach the climber’s ‘right to be let alone’?

¹³⁸ Glantz (1983), pp.77-9.

¹³⁹ See Kole, W. (2007). ‘Court Won't Declare Chimpanzee a Person’. *New York Times*. 27 Sept.

¹⁴⁰ See, for example, *Altitude Sickness - A Patient's Guide* [online],

available:<http://www.medic8.com/healthguide/articles/altitudesickness.html> [accessed 17 June 2006]

¹⁴¹ Hjertaas (1963) in discussing Binswanger’s understanding of a subject being (mentally) *in extremis*, states: “To feel the full sense of the word, imagine a mountain climber trapped on a narrow ledge such that he can neither descend nor ascend, and from which he must be rescued by others”. (p.342)

Example 2: A father seeking to rescue a child from a burning house

A comparable example might be that of a fireman who restrains a distraught father from trying to enter a burning house to save his child, the fireman knowing that rescue is impossible.

Discussion of the examples

Doubtlessly the fireman trespasses on the rights of the father and the climber on those of his companion, but the transitory nature of both trespasses makes them more serious than, but perhaps still comparable to, the jostling which one encounters in walking through a crowd and which, strictly speaking, is legally a battery and thus a trespass, but is perhaps more wisely analysed as part of the unavoidable ‘trespasses’ that are part and parcel of living amongst others in a community.

Though it may seem appropriate to term such interventions ‘paternalistic’ this is not the case as becomes readily apparent when they are examined in the light of Foot’s analysis (*supra*) of the differing obligations flowing from justice and charity. Such interventions certainly accord with charity but they also conflict – but to a minor extent – with justice. To term them ‘paternalistic’ risks masking their trespass against justice and risks implying that interventions are permissible if they are undertaken for paternalistic reasons. Such a conclusion would be diametrically opposed to Foot’s analysis and the standpoint being adopted in this dissertation; accordingly such interventions will be termed ‘quasi-coercive interventions’ so that both the coercive nature of the intervention is patent as is the fact that they are permissible only because the level of coercion employed is minor and tightly circumscribed.

Whereas perhaps many instances of coercive psychiatric interventions are of this nature,¹⁴² others (*e.g.* where an individual is deprived of his liberty for perhaps the greater portion of his life and is forcibly medicated to the extent that his intellectual abilities are considerably reduced) are of a different order of magnitude. Whereas, in relation to the climber or the distraught father or the more minor instances of coercive psychiatric intervention, it might be said that the ‘right to be let alone’ had been

¹⁴² See, for example, the tragic case of David Higgins, a 21 yr. old who had had too much to drink at a party and, perhaps being troubled by what someone had said or done, decided on his way home to climb onto a bridge and jump into a fast flowing river where he drowned. Had the young man been encountered on the bridge and been restrained and sedated until the following morning then this would exemplify the unproblematic psychiatric interventions that are here being adverted to. Such interventions, and suggestions as to how they might be distinguished from more problematic interventions, are discussed in the Conclusions.

The case is reported at:

Carroll, S. (2011). 'Dirt cheap' alcohol linked to suicides in youth, says Shortall.' *The Irish Times*. 4 November; and O'Connell, E. & McNulty, A. (2011). 'Ban cheap booze, says grieving dad'. *The Irish Independent*. 7 November.

infringed; in other, more extreme, cases of coercive psychiatric intervention, the right might best be described as having been effectively destroyed. In such cases, one of the fundamental rights of personhood has been set at naught.

If this is to be justified, then – assuming that necessary and sufficient conditions for personhood have been specified – the context within which justification must be formulated is tightly constrained and well defined. Seen in this light, the use of necessary and sufficient conditions for personhood – though often interpreted as a sword – can provide a very effective mechanism for the defence of rights.

A distinction must also be drawn between those cases where the right ‘to be let alone’ is breached by a private individual (*e.g.* by a kidnapper or a rapist) and those where the breach is by an organ of the state. In this context – because its coercive powers are regulated and enforced by the state, psychiatry functions as such an organ; furthermore in western societies (unlike perhaps in the former USSR) a coercive psychiatric intervention is generally perceived by the wider society as being justified. Thus – in contrast to a kidnapping – a coercive psychiatric intervention, even of a level not sufficient to effectively destroy a subject’s ‘right to be let alone’, can have the most profound effects on how one subjected to such an intervention is regarded by other members of society; in short, it can severely diminish the subject’s Personhood_{SOC}.

F.2.3.2: The term ‘destroyed’ in the context of personhood

When one says that a house has been ‘destroyed’ by a storm or fire one does not mean that every trace of the original house is gone or that no brick is left standing, rather one means that, although vestiges of the house may remain and hints of its original structure may still be glimpsed, it is so severely damaged that, realistically, no remedial work could restore it to its original condition; it is damaged beyond repair, destroyed. It is in this sense that the term is used in speaking about a coercive psychiatric intervention *destroying* a subject’s personhood, especially in the context of Personhood_{SOC}.

As will be argued in Chapter 1, if coercive interventions resulting in the destruction of personhood [*i.e.* in the sense of Personhood_{SOC} or Personhood_{LAW}] are to be justified on philosophical grounds, then this can only occur if the criteria for personhood – assuming such exist and whatever these might be – are not fully satisfied at the time of the original intervention [*i.e.* that Personhood_{ETH} was then in abeyance].

F.2.4: Some remarks on the definition of personhood

Although Foot implicitly drew a distinction between ‘person’ and ‘human’, this distinction is not uncontroversial in that, for example, some philosophers refuse to countenance the possibility that although X might be human, X is not a person. Other philosophers¹⁴³ who accept the distinction between ‘person’ and ‘human’, disagree on whether the distinction can be encapsulated in a set of necessary and sufficient conditions for personhood and, in the event that they do agree, they disagree on what comprises such a set of conditions.¹⁴⁴

Macklin (1983)¹⁴⁵ writing on the competing definitions of personhood, notes that: “... *the large majority of efforts to define personhood are within the context of a single biomedical issue*”¹⁴⁶ and that consequently: “... *they give little guidance for understanding personhood in different contexts.*”¹⁴⁷ She argues that “... *an approach that seeks characteristics of personhood independent of its application in one particular context in bioethics*”¹⁴⁸ is superior and she identifies three such: Joseph Fletcher’s indicators of humanhood, Mary Anne Warren’s and Michael Tooley’s criteria of personhood but she believes that these set standards:

... so high that, while they apply to a wide range of contexts in bioethics, they would rule out neonates, patients with dementing illness, and many individuals labelled mentally ill or mentally retarded.¹⁴⁹

Macklin is not alone in regarding the setting of such standards as being profoundly illiberal in that they have the effect of withholding the term ‘person’ from, for example, an individual with extreme and irreversible dementia. But such a perspective only portrays half the story in that a critique of a specific definition of personhood should only occur if the rights-cluster associated with that particular usage is specified. The widening of the class to whom the term ‘person’ is applied, has as an inevitable consequence, the reducing of the ‘rights-cluster’ to be associated with personhood; for example: to widen the criteria used in specifying personhood so as to include an individual with extreme and irreversible dementia, necessarily has the consequence that

¹⁴³ Amongst whom may be listed: Turing (1950), Leiber (1991), Downie & Telfer (1969), Rawls (1973), Tooley (1972), Kluge (1975), Dennett (1978) [necessary but not sufficient], Fletcher (1979), Flanagan (1991), Drane (1994) and Harris (1994). [See Roche (2000) for further discussion],

¹⁴⁴ The attributes canvassed include ‘ability to reason’, ‘rationality’, ‘ability to communicate’, ‘ability to live a life according to a plan’, ‘possession of a concept of self’, ‘capabilities of symbolic awareness’, ‘minimal level of brain complexity’, ‘minimum intelligence’, ‘self-awareness’ and ‘self-control’.

¹⁴⁵ Macklin (1983).

¹⁴⁶ *Op. cit.*, p.38.

¹⁴⁷ *Ibid.*

¹⁴⁸ *Ibid.*

¹⁴⁹ *Ibid.*

the ‘rights-cluster’ associated with personhood no longer includes the right to refuse a proffered medical intervention to be undertaken in the best interests of the subject. A more nuanced view is required which will acknowledge that the complete ‘rights-cluster’ which is associated with personhood does not, indeed cannot, apply in cases of say, severe dementia or catatonic schizophrenia. This is not to say that such individuals have no rights rather it is to say that they do not have the full complement of rights associated with personhood; in particular they lack the right to say no to proffered assistance undertaken in their best interests. Understood in this manner, the explicit incorporation of personhood (and associated necessary and sufficient conditions) into the debate may function not only as a sword (by justifying the removal of rights) but much more importantly as a shield which seeks to defend the rights of those most vulnerable in society by forcing those who would trespass on their right to ‘be let alone’ to justify the trespass.

It is also important to note that a determination that the criteria in relation to personhood have, or have not, been satisfied is a determination at a specific moment in time and does not preclude the possibility of a contrary determination at some future time.

As mentioned earlier, one consequence of widening the ambit of this dissertation to include aspects of clinical psychiatric practice, is that discussion of other philosophically relevant, topics must be curtailed lest the focus on the dissertation topic, be lost. The philosophical literature on personhood is one such topic; this literature is extensive and, were the circumstances different, would merit discussion and examination but in the present context this discussion must be forgone and decisions must be made to enable the formulation of the argument to proceed; accordingly, it will be assumed:

- (i) that personhood can be defined by a set of necessary and sufficient conditions; and that
- (ii) from these sets of conditions, a set can be chosen¹⁵⁰ such that the only conditions relevant to formulating a justification for a coercive psychiatric intervention, are ‘*rationality*’ and ‘*ability to communicate*’.¹⁵¹

¹⁵⁰ These conditions have been chosen because, *inter alia*:

- psychiatrists often regard ‘irrationality’ as synonymous with ‘mental illness’ [Culver & Gert (1982), p.20].
- ‘ability to communicate’ covers cases (*e.g.* catatonic schizophrenia) where the subject lacks the ability to communicate thus rendering it difficult to justify a finding of irrationality.

The possibility of overlap between these conditions is not problematic because though each is a necessary condition for personhood, when considered singly neither is a sufficient condition.

The dissertation argument which was informally sketched in the preceding sections, will be given a more rigorous formulation in Chapter 1.

¹⁵¹ In this context ‘inability to communicate’ means that the subject lacks the ability to communicate by word or gesture; ‘irrational’ means that that which is communicated (by word or gesture) is not rational.

Chapter 1: The Stage 1 Argument¹

*Much Madness is divinest Sense -
To a discerning Eye;
Much Sense – the starkest Madness -
'Tis the Majority
In this, as All, prevail -
Assent – and you are sane -
Demur – you're straightway dangerous -
And handled with a Chain -*

Lines from a poem by Emily Dickinson.²

As discussed in the Introduction, the formulation of the dissertation argument is based on the concept of personhood and the assumption that it can be defined by a set of necessary and sufficient conditions. It is also assumed that, from such sets of conditions, a set can be chosen in which ‘*ability to communicate*’ and ‘*rationality*’ are the only conditions relevant to the justification of a coercive psychiatric intervention which endangers personhood.³ A further assumption is the principle enunciated by

¹ The dissertation argument is structured in such a way as to examine the abstract question of whether a coercive intervention in the life of another, of a seriousness as might be considered capable of putting their personhood in jeopardy, might be justified on the grounds of the subject’s perceived ‘best interests’. [‘Abstract’ in the sense of having no necessary connection to psychiatry or to psychiatric interventions.] Though the language of psychiatry is used throughout the following chapter, this is for ease of exposition rather than theoretical necessity. The argument is applicable to non-psychiatric interventions such as the case of the subject suffering from asthma who was restrained and intubated against her wishes [see Annas (1999) which is discussed in Chapter 7]. Thus psychiatry has no role to play in the abstract formulation of the argument and features only as a possible application of the analysis. To attempt to introduce psychiatric categories into the abstract structure of the argument would make the endeavour circular and ultimately pointless. The origin or cause of any preexisting damage to personhood is irrelevant to the analysis and such damage must be filtered solely through the conditions of personhood (howsoever specified) and whether or not these have been satisfied at the time of the intervention.

² Dickinson (1997), p.30

³ Other criteria for personhood have been canvassed which may be of relevance to justifying a coercive psychiatric intervention: Fletcher (1979), for example, includes “*self-control*” and “*balance of rationality and feeling*” amongst his set of necessary and sufficient conditions; Rawls (1973) argues “... *that a person may be regarded as a human life lived according to a plan.*” (p.408). The decision to take ‘*rationality*’ and ‘*ability to communicate*’ as the only conditions relevant to justifying a coercive psychiatric intervention is in the nature of a simplifying assumption. These conditions appeared to be the most tractable and the most amenable to enabling the construction of an argument; once constructed then - as with any model - the basic assumptions may be widened to incorporate additional complications and the argument adapted accordingly. The centrality of the concept of ‘*irrationality*’ to psychiatry has been noted by Culver & Gert in their *Philosophy in Medicine: Conceptual and Ethical Issues in Medicine and Psychiatry* where they state that: “ ‘*Rationality*’ and ‘*irrationality*’ are among the most important concepts in both psychiatry and philosophy.” [Culver & Gert (1982), p.20.]

Drawing on the writings of Wittgenstein and Strawson, an alternative approach to analysing personhood and its loss, is suggested in the Conclusions where it is noted that Wittgenstein’s observation that “*Madness doesn’t have to be regarded as an illness. Why not as a sudden – more or less sudden – change of character?*” would in conjunction with Strawson’s (1963) concept of personhood, make an interesting starting point for an argument analogous to that undertaken in the dissertation and which could encompass ideas of psychological (dis)continuity which are of interest to psychiatry.

Philippa Foot, that a person has “*the right to be let alone*” and that this right is fundamental to personhood.⁴

As also mentioned in the Introduction, the concept of personhood is deeply contentious. Not wishing to get embroiled in such a controversy (with the attendant risk of this dissertation losing focus), I will simply set out the assumptions which will be the starting point for my dissertation argument. I do not wish to engage in an extended argument as to why such assumptions should be accepted, I simply wish to take them as axioms; the purpose of my dissertation being to show that the acceptance of these axioms implies a number of conclusions concerning the justifiability of coercive psychiatric practice. Hence the dissertation argument has the form, not that proposition ‘B’ is true, but rather ‘if A, then B’. To those who refuse to accept ‘A’ the argument has little force; to those who do, the argument provides a powerful and focussed tool to analyse justifications for coercive psychiatry.

My reason for using such a form of argument is that the assumptions permit the development of a logically rigorous and tightly focused mechanism for the analysis of such justifications and that once the initial steps are accepted, the argument proceeds along a well-defined path where the possible objections are few and tightly constrained. This is itself a considerable gain in a field where many arguments – though initially promising – are open to being derailed by innumerable side winds with the resulting discussion quickly becoming inchoate.

⁴ Foot (1978):

- “... *the cluster of claim-rights brought together under the title of the right to life. The chief of these is, of course, the right to be free from interferences that threaten life.*” (p.46)
- “*The right to life can sometimes give a duty of positive service, but does not do so here. What it does give is the right to be left alone.*” (p.48)

The status and scope of Philippa Foot’s contention is best understood when seen in the context of the example which she used in setting forth her argument.

Foot envisaged a grievously wounded soldier ‘W’, his comrades being obliged to abandon him having been forced to retreat by the advance of an army known for the brutality with which they treated enemy combatants. A fellow soldier ‘S’ offers to shoot his wounded comrade believing this to be in W’s ‘best interests’, but the wounded soldier refuses the offer. The question posed by Foot is “*Believing that it would be in W’s best interest to be killed, has S the right to do and to disregard W’s wishes?*” Her answer is an unequivocal ‘No’.

The unexpressed but implicit analogy is that of an individual ‘I’ coming across an animal ‘A’ who was mortally wounded and in great distress. Is I under a moral obligation to put A ‘out of its misery’? The implicit conclusion is that whereas the moral obligation that one owes to such an animal is to put it out of its pain, no comparable obligation exists towards persons. On the contrary, argues Foot, our primary obligation to persons is that they possess the “... *right to be let free from unwanted interference*”. It is by virtue of the existence of this obligation that the ethical obligations due to persons are distinguished from those due to animals.

More formally, I wish to adopt three postulates as the basis on which to establish my argument:

Postulate 1. Personhood can be defined⁵ by a set of necessary and sufficient conditions which include criteria as to minimum levels of rationality and ability to communicate.

Postulate 2. From amongst such sets of conditions, a set is chosen such that the only conditions relevant to justifying a coercive psychiatric intervention, are ‘rationality’ and ‘ability to communicate’.

Postulate 3. [Foot (1977)] The ascription of personhood confers a rights-cluster the most fundamental of which is ‘the right to life’; a key element of the right to life is the ‘right to be let alone’.

The refusal to accept the truth of these propositions does not undermine the validity of the argument to follow nor the truth of the argument’s conclusions which can, I believe, be established on grounds other than the ones that I have chosen.⁶

Different meanings of the term ‘personhood’ were identified in the Introduction where the terms ‘diminishment of personhood’ and ‘destruction of personhood’ were also used; the logical relationships between these terms will be examined in Section A. The main argument will then be outlined in two stages. First, an initial draft structure (Section B) which sets out the argument as it might be developed on the assumption that the factual information required to establish the various steps of the argument, was readily available. This, as it turns out, is overly optimistic and the evidential difficulties and lacunae that exist are discussed in Section C where a revised argument structure is developed and where attention is also drawn to the implicit use of ‘default presumptions’ in relation to coercive psychiatric interventions. It is important that such presumptions be made explicit so that they may be subjected to critical scrutiny and Section D contains a proposal as to how the problems associated with the choice of default presumptions might be resolved. In the light of the evidential difficulties which were discussed in Section C, a revised argument structure is presented in Section E which also details how the revised argument will be developed in subsequent chapters.

⁵ The necessary and sufficient conditions referred to in the postulates relate to personhood_{ETH}. The use of the word ‘definition’ in the context of personhood is discussed in Section A.

⁶ Some alternative grounds are suggested in the Conclusions.

Section A: Personhood: some preliminary matters.

In the preceding discussion the term ‘definition’ has been used in relation to personhood; it will be argued in *Subsection A.1* that though the term ‘definition’ is sanctioned by usage, ‘ascription’ would be a more suitable term.

The relationships between the various meanings of ‘personhood’ are discussed in *Subsection A.2* as are the terms ‘diminution’ and ‘destruction’ when used in relation to personhood.

A.1: The use of the term ‘definition’ in discussing personhood

Defining personhood in terms of necessary and sufficient conditions bears a superficial similarity to the defining of many other concepts in terms of necessary and sufficient conditions: *e.g.* X is an ‘even number’ if, and only if, X is divisible by 2. Such a definition of ‘evenness’ in terms of necessary and sufficient conditions fully encapsulates its meaning and, whilst many properties of evenness are not patent in the definition, they can be deduced without the need to transcend the definition. However, definitions of personhood are not like definitions of evenness: it does not follow that X is a person if, and only if, X satisfies a given set of conditions in the sense that ‘person’ is merely a shorthand for the set of conditions and that this set of conditions fully encapsulates the meaning of ‘person’; this is because the ethical implications of X being a person are nowhere evident in, nor derivable from, the definition; furthermore one such ethical implication – that X should be treated by others ‘as a person’ – appears to introduce a note of circularity.

This Gordian knot can be cut by recognising that the necessary and sufficient conditions for personhood are not conditions for its *definition*, not even for its ascription (‘X is described as a person’) but for its *normative ascription*. By this is meant that if X satisfies the necessary and sufficient conditions then X should be regarded by others as a person. The meaning of the term ‘person’ transcends these necessary and sufficient conditions; Foot (1977) captures one aspect of treating another as a person (‘the right to be let alone’) but a rights based context alone is not sufficient in that ‘to treat another as a person’ involves not simply a recognition of rights but requires a gesture of empathy, a recognition of a shared humanity.⁷ It is incompatible with seeing another as ‘other’ –

⁷ For a comparable viewpoint see Dennett (1997):

... it is not the case that once we have established the objective fact that something is a person, we treat him or her or it in a certain way, but that our treating him or her or it in this certain way is somehow and to some extent constitutive of its being a person. (p.270).

Dennett (1997) gives necessary conditions for personhood but believes that it is not possible to specify sufficiency conditions. (p.285).

e.g. as alien or beyond understanding. The same end can be achieved by distinguishing (as was done in the Introduction) between the different meanings of personhood and, in the present context understanding the term as ‘Personhood_{ETH}’ because to speak of X satisfying the necessary and sufficient conditions for Personhood_{ETH} is simply to assert that others should treat X as a person.

A.1.1: The importance of the distinction

The distinction just made in relation to the meaning of ‘definition of personhood’ is of importance when discussing the destruction of personhood because if ‘definition’ is understood in the same sense as it is used in discussing the definition of ‘evenness’ then to speak of X acting in such a manner as to destroy the personhood of Y implies that X’s action resulted in, for example, the destruction of Y’s ability to communicate thus destroying Y’s personhood (the ability to communicate being a necessary condition for personhood).

If, in contrast, the necessary and sufficient conditions used in the definition are understood as normative criteria for the ascription of personhood then to say that X’s action destroyed the personhood of Y implies that his action resulted in either Y’s rights being effectively destroyed or his standing ‘as a person’ in his own eyes, or in the eyes of others, being destroyed. It does not necessarily imply that the necessary and sufficient conditions for Y’s personhood have been breached. Indeed it is from the possible conflict between X’s obligations and the consequences of his action, that his obligation to justify his action, arises.

A.2: Personhood_{ETH}, Personhood_{LAW}, Personhood_{SOC} and the diminution or destruction of personhood⁸

Of the various meanings of personhood discussed in the Introduction, three are of especial importance in formulating the dissertation argument: Personhood_{ETH}, Personhood_{LAW} and Personhood_{SOC}.⁹ These meanings encapsulate separable – but not necessarily separate – aspects of the concept of personhood.

The proposition ‘X has Personhood_{ETH}’ implies that X possesses¹⁰ the associated Rights-Cluster_{ETH} one of the most important elements of which is the ‘right to be let

⁸ These concepts are discussed further in Chapter 7.

⁹ The subscripts will be omitted in contexts where there is no possibility of ambiguity.

¹⁰ The proposition that ‘X has personhood_{ETH}’ is equivalent to stating that X objectively satisfies the conditions for personhood and, in consequence, objectively possesses Rights-Cluster_{ETH}. Strictly speaking, X’s subjective conviction that he is in full possession of Rights-Cluster_{ETH} (and thus has Personhood_{ETH}) is a distinct concept meriting a separate symbol such as Personhood_{ETH-SUBJ} (with an associated Rights-Cluster_{ETH-SUBJ}) but to introduce such a symbol would further complicate an already

alone'. But the proposition (being, as it is, a proposition of ethics) is also an admonition to others that X should be treated by them as a person.

It is, however, a fact of life that such admonitions are not necessarily heeded by those to whom they are addressed. Personhood_{SOC} is a measure (in relation to a particular individual or group of individuals) of the degree to which such admonitions are, or are not, generally respected by society.

Personhood_{LAW} is a measure of the degree to which the rights are legally enforceable. Personhood_{SOC} (and Personhood_{LAW}) are thus empirical estimate of the degree to which the rights bestowed by Personhood_{ETH} are actualised in everyday life.¹¹ Examples of the use of these various meanings in different contexts (such as in relation to the Indian caste system) were given in the Introduction.

A.2.1: Breaches of the rights associated with personhood

Breaches of the rights associated with personhood can be viewed from a number of perspectives:

- from the narrow perspective of the actual act or omission that constituted the breach;
- from the perspective of the individual concerned *i.e.* the effect of the act constituting the breach on their subsequent image of self;
- from the perspective of the wider society *i.e.* the effect of the act constituting the breach on society's subsequent image of the individual subjected to the breach.

These perspectives are not necessarily in alignment: *e.g.* the unwanted physical touching of a woman by a man may, in relation to the actual act in question, be viewed by others as minor but may, to the woman, be deeply intrusive;¹² an inability to get legal redress may accentuate the damage.

complex analysis for little additional benefit. Accordingly in the discussion to follow, unless the concepts need to be distinguished, Rights-Cluster_{ETH} will be understood as also referring to Rights-Cluster_{ETH-SUBJ} (and Personhood_{ETH} as also referring to Personhood_{ETH-SUBJ}); the justification being that if X has a deep and sustained conviction, born of long experience, that he lacks Rights-Cluster_{ETH}, the (philosophical) assertion that he does not – as distinct from asserting that he should not – would appear to be needlessly gratuitous.

¹¹ For example, an editorial in the Israeli newspaper *Haaretz* has stated that Israelis “...*have become accustomed to treating the Palestinians as inferior people.*”; a sentiment echoed more forcefully by former US President Carter who stated that “*the citizens of Palestine are treated more like animals than like human beings.*”

Haaretz (2009). ‘Editorial: Something bad is happening to us.’ *Haaretz*, 25 February; [online], available: <http://www.haaretz.com/hasen/pages/957536.html> [accessed: 25 February 2008].

France 24 (2009). ‘Palestinians ‘treated like ‘animals’: Jimmy Carter.’ *France 24*. 16 June. [online], available: <http://www.france24.com/en/20090616-palestinians-treated-like-animals-jimmy-carter> [accessed: 29 May 2010].

¹² Consider, for example, the act of a man forcing a veiled Muslim woman to unveil.

Similarly, a coercive psychiatric intervention must be viewed from a number of perspectives: that of the psychiatrist, the subject and the wider society:

- *the psychiatrist* who may see only the provision of necessary medical treatment;
- *the subject* who may consider the coercive intervention as a deeply intrusive act which irremediably damages his sense of autonomy in that his demonstrable inability to prevent such an intrusion, raises the possibility of its reoccurrence in the future;
- *the rest of society* who may stigmatise those diagnosed as being mentally ill, especially if the intervention entailed an involuntary hospitalisation. Such intervention leaves “... *an indelible ‘mark’ metaphorically that sets apart the stigmatized individuals who become ‘in some way morally diminished.’*”¹³

Any assessment of the consequences of a coercive psychiatric intervention must take account of these differing perspectives; but the fact that a coercive psychiatric intervention has particular consequences does not necessarily imply that the psychiatrist bears responsibility for them nor should be required to justify them.

Consideration of a medical non-psychiatric condition may help disentangle the various issues involved.

Leprosy is a condition which, as a matter of sociological fact, results in the subject diagnosed being, to some extent, stigmatised and treated as a social pariah. The doctor who diagnoses leprosy in a subject is not thereby responsible for the stigma that may follow. However, knowing that stigma will be a consequence of the diagnosis accentuates his responsibility to ensure that the diagnosis is correct. If through want of care, a misdiagnosis does occur then the physician bears responsibility for the consequences of the wrongful diagnosis including the stigma.

Similarly, the psychiatrist who diagnoses a mental illness in a subject is not thereby responsible for the stigma that such a diagnosis may entail except in circumstances where it was a negligent misdiagnosis.¹⁴ The situation is different in the case of a

¹³ Siever (2007) in a review of Thornicroft (2006). Thornicroft (2006) was the recipient of a British Medical Association award, the citation stating:

Once a person is labelled mentally ill, their decision-making ability is called into question and protests against treatments are either discredited or labelled as one more symptom of mental illness. ... The solution is not seen as lessening stigma but as ensuring people labelled as mentally ill retain the right as citizens to challenge the label and their treatment as well as the right to retain basic control over their lives. Perhaps from this recognition, a civil rights movement may grow, dedicated to the liberation of people with mental illness from being marginalised, from being excluded and from being shunned.

¹⁴ The term ‘misdiagnosis’ is, within psychiatry, capable of a number of distinct meanings such as when:
(i) a sane individual is diagnosed as being mentally ill.
(ii) a mentally ill individual is diagnosed (incorrectly) as suffering from a specific mental disorder.

coercive psychiatric intervention because – since it involves a breach of the right to be let alone – it and the consequences that naturally flow from it (including the further stigma entailed by a coercive intervention)¹⁵ require justification.

A.2.2: Coercive psychiatric interventions and consequent damage to personhood¹⁶

The detrimental social consequences of either a psychiatric misdiagnosis or a coercive psychiatric intervention, can be described in terms of Personhood_{SOC} and, depending on the severity of the stigma, its diminution or effective destruction.¹⁷

The effects of a coercive psychiatric intervention can also be described in terms of Personhood_{ETH}, Personhood_{LAW} and their associated rights-clusters. As discussed in the Introduction, a coercive psychiatric intervention under the Irish Mental Health Acts is – absent circumstances suggesting *male fides* – for practical purposes beyond legal challenge. The deference shown by the Irish courts to psychiatric opinion in such matters, is such as to render the opinion of a psychiatrist that (in any particular case) a coercive intervention is appropriate, determinative. Furthermore the professional opinion of a psychiatrist has – by virtue of his status – an authority that extends beyond the confines of a psychiatric institution, to society at large; thus a psychiatric ‘determination’ that an individual’s ‘right to be let alone’ is in the particular instance and at that moment in time in abeyance, will (generally) command both the assent of the courts and of the wider society. Such an intervention may be transient and comparable to the example of the climber suffering from altitude sickness¹⁸ but it may also be deeply invasive (Manweiler described the effects of the coercive psychiatric treatment as making him like a “zombie”)¹⁹ and persist for many years (as occurred in the Manweiler case).

If the intervention has been of the latter type, the fact that it ceases at some moment in time, does not restore the *status quo ante* if for no other reason than the subject’s awareness that what was so easily removed from him before – namely, his ‘right to be

This distinction immediately raises the question as to the criteria that are being used when an individual is diagnosed as being mentally ill (*simpliciter*). The ambiguities inherent in the term will be discussed in Chapter 4.

As used in the present context, ‘misdiagnosis’ refers to a situation where had the misdiagnosis not been made, the coercive psychiatric intervention would not have occurred.

¹⁵ A stigma additional to the stigma consequent on being diagnosed as being mentally ill because the use of a coercive intervention may be taken to imply either that the subject was dangerous or was grossly irrational; these perceived ‘deficiencies’ may well adhere to him long after he has been released.

¹⁶ See Chapter 7 for a further discussion of these issues.

¹⁷ The distinction between ‘destruction’ and ‘effective destruction’ was discussed in the Introduction; see also Chapter 7.

¹⁸ See Introduction.

¹⁹ See Appendix H.

let alone' – can be removed again. In such circumstances his Rights-Cluster_{LAW} (and, to his mind, Rights-Cluster_{ETH}) may have been effectively, and authoritatively, set at naught.

Before turning to a consideration of possible justifications, some clarification of terminology is necessary:

- the term '*destruction of personhood*'²⁰ refers to an intervention which results in the effective destruction of the 'right to be let alone' and, consequently, of Personhood_{ETH}.
- the terms '*grievous diminishment of personhood*' or '*grievous damage to personhood*'²¹ focus not only on any diminishment of rights of the subject but also on any stigma entailed by the coercive intervention;²² these terms refer to an intervention which has the effect of grievously diminishing Personhood_{SOC} and Personhood_{LAW};
- coercive psychiatric interventions of a level of invasiveness as to result in either the destruction, or the grievous diminishment, of a subject's personhood will be termed '*radical interventions*'
- lesser levels of diminishment of Personhood_{SOC} and Rights-Cluster_{LAW} are spoken of as '*diminishment of personhood*' or '*damage to personhood*'.

The effects of a coercive psychiatric intervention on the personhood of a subject is the focus of Chapter 7 where it will be argued that – whilst many such interventions could not be said to either grievously diminish or destroy personhood – cases exist where such terms are appropriate; two such examples²³ are discussed in the Appendices where the grievous diminution of personhood which occurred in these cases, was attributable to the coercive nature of the psychiatric intervention.

Accepting, for the purposes of argument, that radical psychiatric interventions exist, the question arises as to how such interventions might be justified.

A.2.3: Permissible justifications for a radical intervention

The postulates imply that: If X is a person [*i.e.* X satisfies the necessary and sufficient conditions for personhood] then X is entitled to be treated by others as a person and to have his right to be let alone respected.

²⁰ See Chapter 7 for a further discussion of these issues.

²¹ *Ibid.*

²² But not that entailed by the diagnosis except in cases of misdiagnosis.

²³ Juklerød and Manweiler in Appendices G and H respectively.

Consequently if a psychiatrist ‘P’ subjects Y to a coercive psychiatric intervention, which is of such a nature as to result in either:

- the extreme diminution of Personhood_{SOC}, or Personhood_{LAW}
- the effective destruction of the right to be let alone (and thus of Personhood_{ETH-SUBJ})

then the *only* justification available to P (in the context of the Stage 1 argument *i.e.* excluding considerations of dangerousness) is that Y does not satisfy one of the sufficiency conditions for personhood. ‘Irrationality’ and ‘inability to communicate’ are the only relevant sufficiency conditions, hence P must argue that X displays a level of irrationality or inability to communicate sufficient to breach the criteria for personhood.

Section B: The Stage 1 argument structure: initial outline

Step 1: Postulates 1-3 (*supra*).

Step 2: A coercive psychiatric intervention may be of such a level of intrusiveness as to destroy, or grievously damage, the personhood of the subject.

Such interventions are called ‘*radical interventions*’. It will be shown that interventions of such intrusiveness occur and the argument will focus primarily on seeking to determine the philosophical justification for such interventions.

Step 3: A radical coercive psychiatric intervention can only be justified, philosophically, if the subject has not satisfied the sufficiency conditions for personhood in relation to either rationality or ability to communicate.²⁴

Step 4: The level²⁵ of irrationality that would justify, philosophically, a finding that personhood was endangered, is denoted by ‘L₁’.

Step 5: Psychiatrists in their practice, sometimes adjudge that a coercive psychiatric intervention is required.

Some of these are radical interventions *i.e.* of an intrusiveness sufficient to destroy or grievously damage personhood. The level ‘L₂’ of irrationality implicitly or explicitly used by the psychiatrist in

²⁴ For convenience only the rationality criterion is alluded to in discussing the remainder of the argument structure; the development in relation to ‘ability to communicate’ is similar.

²⁵ It is assumed that rationality can be measured on a linear scale; this is simply a heuristic device adopted for convenience of exposition.

justification of such radical interventions is determined.

In other words, the justification used by the psychiatrist for the intervention is viewed solely through the prism, or filter, of rationality, anything extraneous to an assessment of the rationality of the subject is disregarded.

Step 6: If L_2 exceeds L_1 , then a radical intervention may be justified (philosophically) provided it is, in fact, in the subject's best interests.

Step 7: An assessment of past coercive psychiatric interventions [both radical and non-radical] is made to determine whether interventions which had at the time been justified by psychiatrists as being in the subject's best interests, were in point of fact beneficial to the subject. Any damage to the subject's personhood must be included in any such assessment.

Step 8: (i) The proportion of radical interventions which cannot be justified [*i.e.* where L_2 is less than L_1] is determined.

(ii) The proportion of coercive interventions which had been justified on the grounds of the subject's best interests but which in point of fact had been detrimental to the subject, is determined.

Section C: Unfolding the argument

To establish the Stage 1 argument a number of questions need to be answered:

1. Can coercive psychiatric interventions be of such a level of intrusiveness as to destroy or grievously damage, personhood? – that is, do radical coercive psychiatric interventions exist?
2. From the perspective of clinical psychiatry, what is the level of irrationality ' L_2 ' that must be exhibited by a subject in order to justify a radical coercive psychiatric intervention, based solely on the subject's perceived best interests?
3. Can the level of irrationality ' L_1 ' sufficient to (philosophically) endanger personhood, be ascertained?
4. Does L_2 exceed L_1 ?
5. Generally speaking, can the benefits and detriments consequent on a coercive psychiatric intervention be determined and can the benefits be clearly shown to outweigh the detriments?
6. (Based on the responses to Questions 1–5) What proportion of coercive psychiatric interventions lack philosophical justification?

Among the questions necessary to complete the *Stage 2* and *Stage 3* arguments are:

1. How reliable are psychiatric assessments of dangerousness?
2. What proportion of those coercive psychiatric interventions which are justified psychiatrically on the grounds of a subject's dangerousness to others, lack philosophical justification?

These questions will be discussed in Chapter 6.

Of the questions listed above relating to the *Stage 1* argument, the first will be dealt with in Chapter 7.

The remaining questions center on two issues:

- the psychiatric assessment of irrationality, and
- the psychiatric assessment of benefit [*i.e.* of a subject's best interests].

Conclusions concerning the second of these will be drawn in Chapters 4 and 5 which focus on psychiatric diagnosis and treatment respectively.

The question which presents the most significant difficulties concerns the psychiatric assessment of irrationality and, in particular, the determination of L_2 . The need to determine L_1 – and the assessment of whether L_2 exceeds L_1 – arises only if L_2 has been determined. Hence an exploration of how psychiatrists adjudge a subject as being 'irrational' takes center stage; ideally such an exploration should provide an estimate of L_2 . Some of the difficulties that any such exploration may encounter are discussed in *Subsection C.1*. In the light of these difficulties, a reformulation of the argument is undertaken in *Subsection C.2*.

C.1: The determination of L_2 and other evidential problems

The first problem to arise concerning the determination of L_2 concerns whether psychiatrists themselves are reliable judges of how they ascribe irrationality; an observation by Professor Milos Jenicek²⁶ is instructive. Jenicek (2003) began his opening address to a conference²⁷ on '*Evidence Based Psychiatry*' by noting: "*Such lack of attention to logic and critical thinking in psychiatry may be found even at the very core of clinical psychiatric practice.*"²⁸ This suggests that the psychiatric usage of

²⁶ Professor (McMaster), Professor Emeritus (Montreal) and Adjunct Professor (McGill).

²⁷ XLIII Congresso Nazionale della Societa' Italiana di Psichiatria which was held at Bologna in October 2003.

²⁸ Jenicek (2003); he continued:

For example, the assessment of a patient's thought content and structure is an integral part of a psychiatric interview and largely determining for the diagnosis of psychosis and other problems. ... do we have and do we need clearer inclusion and exclusion criteria to allow us to conclude that a patient's thought process is tangential, that his ideas are taking off in several directions at once?

the term ‘irrational’ might be less than reliable and that third-party independent assessments would be required. There is, however, a dearth of third party independent accounts of how a subject ‘presents’ to a psychiatrist in the time before the psychiatrist adjudges the subject to be irrational.²⁹

The difficulty encountered in one such extended analysis³⁰ was of a magnitude such as to, effectively, render impossible its repetition on a scale sufficient to enable the completion of randomised trials. This analysis is discussed in *Subsection C.1.1* and leads to the conclusion that the original formulation of the problem is intractable and requires reformulation; an analogous problem is discussed in *Subsection C.1.2*, suggesting a possible method of recasting the original problem.

C.1.1: A sociolinguistic analysis of a psychiatric interview

Branca Telles Ribeiro, an academic sociolinguist, was a non-participating observer to a set of interviews between a psychiatrist and his subject. Using the sociolinguistic tool of ‘frame analysis’,³¹ she analysed the interviews and published the results of her study in a book entitled *Coherence in Psychotic Discourse*.³²

The subject had been deemed by the psychiatrist to be incoherent³³ yet Ribeiro’s analysis showed that the ‘incoherence’ was more apparent than real and that the term was being used to describe a refusal by the subject to participate in the interview on the terms decreed by the psychiatrist:

The patient does not follow turn-taking rules; that is, she does not alternate speaker and hearer roles.³⁴ ... By refusing to participate in the conventional frame for the situation, one’s behaviour is regarded as crazy or deviant. ... By agreeing to participate, one is regarded as “normal”.³⁵

Ribeiro concludes:

Frame analysis indicates that the patient’s discourse in the admitting interview, though seemingly incoherent on one level, is coherent on another. The patient consistently created different frames of talk and assessed correctly the frame she

Does psychiatry need better guides to tell us how to assess a patient’s argumentation? Does a psychiatrist always know what is a good or bad argument?

²⁹ The existence of such accounts would permit the psychiatric determination of irrationality to be compared to third party, independent, determinations.

³⁰ Ribeiro (1994).

³¹ The concept is due to Gregory Bateson who suggested that it be understood by analogy with the picture frame. According to Bateson, “ ... *the picture frame is an instruction to the viewer that he should not extend the premises which obtain between the figures within the picture to the wallpaper behind it.*” [Ribeiro (1994), p.50].

³² Ribeiro (1994).

³³ The term ‘incoherent’ implies an inability to communicate and thus is relevant to a discussion concerning assessments of whether conditions for personhood have been breached.

³⁴ *Ibid.* p.12.

³⁵ *Ibid.* p.14.

was in. As Goffman says, “A frame perspective. . . allows us to generate crazy behaviour and to see that it is not all that crazy”.³⁶

Ribeiro uncovered a coherence where others, less diligent and less skilled, might readily have labelled the subject as ‘incoherent’.

In that a global ascription of incoherence to a subject, made by one with the authority to command that their opinions are respected, may result in the destruction of, or grievous damage to, personhood, it is clearly of importance that such judgements be made with the greatest care and circumspection. Yet evidence gleaned from the academic literature on psychiatry (discussed in Chapter 2) suggests that such ascriptions are sometimes made without a full awareness of the gravity of their possible consequences: Berrios (1991), for example, seeks to categorise psychiatric delusions as “empty speech acts”.³⁷ Read (2003) is even more extreme in that he argues that “impenetrable cases of schizophrenia” are not just cases of incoherence: “... but, despite appearances, of no sense, no form of life, at all.”³⁸

Studies such as Ribeiro’s draw attention to an important point namely that psychiatric case histories – the ‘facts’ as seen through the lens of psychiatry – may show substantial divergences from more impartial descriptions. Yet it is precisely such third party independent accounts that are required for the development of the dissertation argument; more specifically, in order to determine L₂ it is necessary to gain access to a representative sample of psychiatric interviews which precipitated a radical intervention and, in addition, to get contemporaneous independent assessments as to irrationality or inability to communicate of these same subjects during these same interviews. The complexity of studies (such as Ribeiro’s) renders their repetition on a large scale, effectively impossible. This might seem to suggest that we are forced to rely on self-reports by psychiatrists of how they assess irrationality. Such a conclusion would be premature because the problem can be tackled indirectly as is suggested by a consideration of the following, superficially dissimilar, problem.

C.1.2: An analogous problem

A teacher of French and Latin has tested his students’ competence by means of both an oral and a written examination. His assessment that a particular student was, in his oral French examination, ‘incompetent’ is being reviewed by a Departmental Inspector. A

³⁶ *Ibid.* p.244.

³⁷ *Op. cit.*, p.8.

³⁸ *Op. cit.*, p.115. [Emphasis in original].

complicating factor is that no independent observer was present at the French oral examination. How might the Inspector proceed?

At least two avenues of investigation are open to him:

- (i) he can review other contexts where the teacher used the term ‘incompetent’ [e.g. oral Latin] and,
- (ii) he can review other determinations made by the teacher where an independent assessment is possible [e.g. written French and Latin papers].

The first of these methods concerns the teachers usage of the term ‘incompetent’ [the ‘*incompetency usage*’ review]; the second concerns the general reliability of the teachers determinations [the ‘*reliability*’ review].³⁹

C.2: *The reformulated problem*

The argument in its initial formulation required a determination of L_2 ⁴⁰. As shown earlier, this resolved into two more basic problems:

- (i) the level of irrationality as assessed by a psychiatrist and regarded by him as (psychiatrically) justifying a coercive intervention (call this L_2^*), and
- (ii) an assessment by an independent observer as to whether L_2^* was an accurate measure of irrationality.

If it was accurate, then $L_2^* = L_2$ and the argument could proceed without any need to question assessments of irrationality as made by a psychiatrist or to distinguish between L_2 and L_2^* .

As mentioned above, independent appraisals of psychiatric assessments of irrationality, to a standard that they could be regarded as having general applicability, are not available hence any attempt to determine L_2^* directly, must be forgone.

Transposing the analysis of the analogous problem (*supra*) into the context of psychiatric determinations of irrationality, suggests that the inability to determine L_2^* can be overcome⁴¹ by:

- examining the psychiatric usage of the term ‘irrationality’ [the ‘*irrationality usage*’ review] and
- examining the general reliability of clinical psychiatric determinations [the ‘*reliability*’ review].

³⁹ Transposing the analogy into the context of psychiatric determinations of irrationality, the first option concerns determining the psychiatric usage of the term ‘irrationality’ [the ‘*irrationality usage*’ review]; the second concerns the general reliability of clinical psychiatric determinations [the ‘*reliability*’ review].

⁴⁰ The level of irrationality that must be exhibited by a subject in order to (psychiatrically) justify a radical coercive psychiatric intervention, based solely on the subject’s best interests.

⁴¹ Implicit in this statement is the ‘*default presumption problem*’ i.e. in case of doubt, in whose favour or in what manner, should the doubt be resolved. See discussion *infra*.

A clarification is necessary in relation to the meaning, in the present context, of ‘reliability’ and this is undertaken in Subsection C.2.1. The ‘irrationality usage’ review is discussed in Subsection C.2.2. The ‘reliability’ review is discussed in Subsection C.2.3.

C.2.1: ‘Reliability’ – a clarification

It is important to note that in examining the reliability of psychiatric assessments, it is not the deviation from ideal standards *per se* that is of relevance but whether, in situations where such deviations exist, the possibility of error is acknowledged or denied. If deviations exist and yet their possibility is denied, then, except in the most unusual circumstances, conclusions may be drawn in relation to the general reliability to be accorded to psychiatric assessments and, in particular, to psychiatric assessment of irrationality. The following example may help clarify.

A feverous traveller

A traveller, recently returned from the Tropics, is admitted to hospital, seriously ill and with a high fever. The medical specialists are unable to determine the nature of the fever; one doctor, with some slight experience of tropical illnesses, suggests that it might be disease ‘W’. He is unsure, but it is his best guess. If indeed the traveller is suffering from ‘W’ then treatment ‘Z’ may work but it is relatively untested. In such a case the physician is unsure both of his diagnosis and of the appropriate treatment but he is conscious of the tentative nature of his judgments and the experimental nature of his treatment and he may be expected to proceed with circumspection.

An alternative scenario is possible: the physician is overconfident of his diagnosis and furthermore, believes erroneously that the treatment that he proposes is securely grounded in evidence-based studies.

It is the prevalence of this latter scenario within clinical psychiatry, that is of importance in judging the reliability of psychiatric assessments in relation to the general assessment of reliability.

C.2.2: The ‘irrationality usage’ review

This review will consist of an examination of the psychiatric usage of the term ‘irrational’ using, for example, journal articles, textbooks, case histories, diagnostic manuals with a particular emphasis on the psychiatric concept of ‘delusion’ which, to the philosophical mind, embodies the very epitome of irrationality.

The goal of the review is to determine whether psychiatrists use the term with a precision and a circumspection that bespeaks measured judgment manifesting an awareness of the damage that can be occasioned by its inappropriate use or, on the contrary, whether they use the term loosely as a catch all to denote something akin to ‘unreasonable’ or ‘strange’.

A conclusion would permit inferences to be drawn⁴² as to the likelihood that psychiatrists, in using the term ‘irrational’ in the context of a radical intervention, do so in a deliberative, authoritative sense thus making the search for L_2 feasible; or, on the contrary, manifest a usage that so lacks precision that any hope of determining L_2 must be forgone. The latter conclusion would also imply that a psychiatric assessment that a subject manifested irrationality of such a level as to put personhood in doubt, should be regarded with a degree of scepticism.

Even if it is found that the psychiatric usage of irrationality is strictly circumscribed, rigorous and precise, a further difficulty arises concerning whether L_2 is determinable. Linear scales, which purport to measure irrationality, exist⁴³ and studies have sought to establish the relationship between the results of such tests and particular psychological dysfunction such as depression or anxiety.⁴⁴ However not only have I been unable to identify any scales which relate to coercive psychiatric intervention but the criteria used by such scales – e.g. “*demand for approval*”, “*high self-expectations*”, “*nonassertiveness*”⁴⁵ – bear such scant relationship to any possible meaning of ‘irrationality’ as might occur in relation to specifying conditions for personhood, as to render them of little relevance. If it is indeed the case that L_2 is not determinable then this, in turn, will render impossible the determination of the proportion of cases where L_2 is less than L_1 and consequently removes the need for determining L_1 .

If, on the contrary, the psychiatric usage of irrationality is found to be vague and imprecise then this would clearly preclude the possibility of determining L_2

⁴² Though it should be borne in mind that a precise usage of the term ‘irrational’ in an academic context is no guarantee of a similar precision in relation to its ascription in a clinical context.

⁴³ E.g. the Irrational Beliefs Test (IBT); Erickson (1991):

The IBT is a widely known device consisting of 10 subscales corresponding to 10 common irrational beliefs articulated by Ellis (1962). Daly and Burton found that four of these subscales (namely, demand for approval, high self-expectations, anxious overconcern, and problem avoidance) were the best predictors of low self-esteem,

⁴⁴ Erickson (1991):

Many authors representing various classical schools of psychotherapy have focused on the role of irrational beliefs in the etiology of psychological dysfunction ... In more recent years these seminal speculations have been corroborated by myriad studies reporting significant relationships between general measures of irrationality and a wide array of psychological problems including anger (...), anxiety (...), depression (...), low self-esteem (...), nonassertiveness (...), poor problem-solving (...) and schizophrenia (...). [References omitted].

⁴⁵ *Ibid.*

Some examples⁴⁶ of assessments of irrationality precipitating coercive intervention, exhibit a ‘methodology’ so informal and unstructured as to belie its name and to suggest that any attempt to determine L₂ would be futile but a final conclusion must await the examination of the psychiatric usage of irrationality which will be undertaken in Chapters 2 and 3.

C.2.3: The ‘reliability’ review

This review consists of an examination of psychiatric determinations made in other areas of claimed expertise (*e.g.* psychiatric diagnosis, psychiatric treatment, psychiatric assessments of dangerousness) to assess how claims to rigor and minimal error in these other areas compare with independent assessments (if such are available).

As mentioned earlier, if deviations exist which are denied then conclusions may be drawn⁴⁷ concerning the reliability of psychiatric assessments of irrationality. Thus, for example, if:

- psychiatrists assert that their diagnostic techniques are robust and seldom prone to error, whilst a subsequent investigation uncovers substantial levels of misdiagnosis, or if,
- psychiatrists assert that their treatments are not only not harmful but beneficial and are securely grounded in evidence-based studies, whilst subsequent investigation shows:
 - that some treatments lack a robust evidence base, or
 - that some treatments cause serious harm, or if,
- psychiatrists assert that their assessment of a subject as being ‘dangerous to others’, is rigorously grounded – assertions which subsequent investigation shows to be deeply flawed,

then the conclusion can be drawn⁴⁸ that a psychiatric assertion that a particular subject manifested a level of irrationality so grave as to warrant a coercive psychiatric intervention (and of a level L₁ such that the rationality criterion for personhood was in question)⁴⁹, should be regarded as of doubtful reliability.

The argument embodied in the previous paragraphs can also be represented schematically by means of the following tables:

⁴⁶ See, for example, *Z. v Khattak & Anor* (2008) (*supra*); the Amy, Manweiler and Juklerød cases (see Appendices).

⁴⁷ See default presumptions *infra*.

⁴⁸ *Ibid.*

⁴⁹ This condition is included to cover circumstances where - because of the lack of rigor in the psychiatric usage of ‘irrational’ - L₂ is not determinable; it relies on conclusions concerning default presumptions to be discussed below.

<i>Reliability of psychiatric diagnoses</i>	<i>Reliability of psychiatric treatments</i>	<i>Reliability of psychiatric assessments of dangerousness</i>	\rightarrow^{50}	<i>General reliability of psychiatric determinations</i>	\rightarrow	<i>Reliability of a psychiatric determination of 'irrationality'</i>
Poor	Poor	Poor		Poor		Poor
		Reasonable		Poor		Poor
		Excellent		Poor		Poor
Reasonable	Poor	Poor		Poor		Poor
		Reasonable		Poor		Poor
		Excellent		Poor		Poor
Excellent	Poor	Poor		Poor		Poor
		Reasonable		Poor		Poor
		Excellent		Poor		Poor
Poor	Reasonable	Poor		Poor		Poor
		Reasonable		Poor		Poor
		Excellent		Poor		Poor
Reasonable	Reasonable	Poor		Poor		Poor
		Reasonable		Reasonable		Reasonable
		Excellent		Reasonable		Reasonable
Excellent	Reasonable	Poor		Poor		Poor
		Reasonable		Reasonable		Reasonable
		Excellent		Reasonable		Reasonable
Poor	Excellent	Poor		Poor		Poor
		Reasonable		Poor		Poor
		Excellent		Poor		Poor
Reasonable	Excellent	Poor		Poor		Poor
		Reasonable		Reasonable		Reasonable
		Excellent		Reasonable		Reasonable
Excellent	Excellent	Poor		Poor		Poor
		Reasonable		Reasonable		Reasonable
		Excellent		Excellent		Excellent

Table 1-1: Indirect assessment of the reliability of psychiatric assessments of irrationality

<i>Psychiatric usage of the term 'irrationality'</i>	<i>General reliability of psychiatric determinations</i>	<i>Possibility of determining L_2</i>
precise	excellent	yes
precise	poor	no
vague	excellent	no
vague	poor	no

Table 1-2:⁵¹ Possibility of determining L_2

The proceeding analysis implicitly relied on some conclusions concerning default presumptions; these will now be examined.

Section D: Default Presumptions

As suggested in earlier discussion, evidence sufficient to conclusively determine questions central to the dissertation argument, is not available. In such cases, the problem arises as to how to resolve doubt when the circumstances are such that leaving the matter open for later resolution is not feasible. An example of such a problem (and

⁵⁰ *I.e.* implies; see default presumptions *infra*.

⁵¹ Tables are numbered and include a chapter reference, thus Table 1-2 is the second table in Chapter 1.

its resolution) is provided by the presumption of innocence in a criminal trial which is to the effect that doubt must be resolved in favour of the accused and not of the prosecutor.⁵²

In relation to coercive psychiatric interventions, doubt can arise at many stages: the diagnosis which grounds the intervention may be a misdiagnosis; the proposed coercive treatment may be of doubtful benefit, the assessment of dangerousness may be based on tenuous premisses. Such doubts are often resolved without their existence – or the principles underlying their resolution – being made explicit such as, for example, when a court simply assumes that someone alleged to be suffering from a psychiatric disorder will benefit from a coercive intervention.⁵³

The ‘*default presumptions problem*’ asks the question: *In case of doubt, in whose favour or in what manner, or on what principles should the doubt be resolved?* In relation to coercive psychiatry it encompasses:

- (i) the need to make explicit the default presumptions that commonly underlie a decision to initiate a coercive psychiatric intervention, *e.g.* that the diagnosis which grounds the decision, is reliable; that the proposed treatment is evidence based and will, in fact, benefit the subject.
- (ii) the need to determine the principles that should underlie the choice of such default presumptions.

Lack of data increases the importance of subjecting default presumptions to analysis because, in the absence of complete information, it is such presumptions that will be determinative of decisions to precipitate a coercive psychiatric intervention.

The problem occurs not only in relation to proposed coercive interventions, but also in relation to reviews of past decisions: in cases where there is substantial – but not conclusive – evidence of a psychiatric misdiagnosis, should the decision be to exonerate the subject from the possibility of stigma or to exonerate the subject’s psychiatrist from the possibility of blame?⁵⁴

⁵² Contrast this principle with the psychiatrist Watler’s attitude when presented with a recalcitrant individual for psychiatric evaluation. Watler’s ‘default position’ is to urge involuntary committal for evaluative purposes; he states: “*It seems speculative to conclude that Amy was not mentally ill*”. [see Appendix C].

⁵³ See, for example, McGuinness J. in *Gooden v St. Otteran’s Hospital* (2005) (*supra*) citing with approval *In re Philip Clarke* (1950) :

The impugned legislation is of a paternal character ... We do not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others.

⁵⁴ See, for example, Witztum (1995b) *infra*.

The problem also arises on a more general level: in the absence of authoritative estimates of psychiatric misdiagnosis, should the possibility of psychiatric misdiagnosis be regarded as anecdotal until definitive evidence becomes available or should an alternative stance be taken?

The ‘*Precautionary Principle*’, – which is discussed in *Subsection D.1* – offers a possible mechanism to tackle the default presumptions problem; its application to coercive psychiatric practice is discussed in *Subsection D.2*.

D.1: The Precautionary Principle

Towards the end of the last century the so-called, ‘*Precautionary Principle*’ emerged as a tool which was useful in the assessment of developmental projects which might have a severe impact on the environment; the principle was defined at the 1992 United Nations Conference on Environment and Development⁵⁵ as follows:

When there is reason to suspect threats of serious irreversible damage, lack of scientific evidence should not be used as a basis for postponement of measures aimed at preventing degradation of the environment.⁵⁶

The principle is not restricted to environmental damage but can be formulated more broadly:

When an activity raises threats of harm to human health or the environment, precautionary measures should be taken, even if some cause and effect relationships are not fully established scientifically.⁵⁷

The application of the principle to medical decision making is controversial,⁵⁸ Boissier (2003), however, isolates a number of points which are of use in the present context:

1. There is an obligation to evaluate the risks of all possible outcomes.⁵⁹
2. When the risks are unclear, the Precautionary Principle implies a reversal of the burden of proof (*i.e.* rather than the onus being placed on the objector to a

⁵⁵ Also known as ‘*The Rio Earth Summit*’.

⁵⁶ Boissier (2003), p.319.

⁵⁷ deFur & Kaszuba (2002).

See also *The Interdepartmental Liaison Group On Risk Assessment (UK)* (2002) which adopts a similar definition.

⁵⁸ Boissier (2003), for example, argues that the Precautionary Principle has no application in relation to individual clinical decisions but only has relevance to policy decisions.

Some commentators (*e.g.* ter Meulen (2005)) seem to base their objection on an unduly wide statement of the principle:

This principle holds that one should not act when there is no scientific proof that no harms will result from a medical act or a policy decision. However, in clinical practice there is a duty to act. Physicians have an obligation to do good to their patients and have to weigh the benefits against possible harms and burdens.

ter Meulen’s ‘duty to act’ is in clear breach of Foot’s ‘right to be let alone.’ [See *infra*]

⁵⁹ Boissier (2003), p.319:

Implementation of the PP requires an ability to evaluate risks. ... risks must be anticipated (according to the “better safe than sorry” approach, which is similar to the “do no harm” principle in medicine),

proposal to show that the risks inherent in the proposal are grave, the onus is on the proposer to show that the risks are not grave.)⁶⁰

Are these principles applicable to psychiatric practice and, if so, how should they be applied?

D.2: Coercive Psychiatry and the Precautionary Principle

In that a medical intervention can have potentially severe or irreversible outcomes and the risks of such outcomes are sometimes unclear, the Precautionary Principle would appear to have a role to play in medical decision making. The main objection against its use in clinical medicine is that it is not relevant: the physician is under an obligation to tell the patient “*what we know and, above all, what we know that we do not know.*”⁶¹ and once this obligation is fully discharged and the patient gives an informed consent to the intervention, then any attempt at applying the Precautionary Principle would serve no useful purpose. This argument is also valid in relation to non-coercive psychiatry⁶² but it has no purchase in relation to coercive psychiatry. What then is the relevance of the Precautionary Principle to coercive psychiatry?

Consider, for example, the problem posed by psychiatric misdiagnosis.⁶³ In the absence of authoritative estimates of the rate of coercive interventions that are grounded in a psychiatric misdiagnosis, a number of questions may be posed as to the conclusions that may be drawn from the (limited) evidence which is available:

- Should examples of psychiatric misdiagnosis be regarded as isolated and unrepresentative, until definitive studies are made?⁶⁴
- Should some of the older studies on psychiatric misdiagnosis – such as Rosenhan (1973)⁶⁵ – be regarded as historical curiosities and of no current relevance?
- Should some of the studies on psychiatric misdiagnosis which examined narrow subcategories (*e.g.* the link between race and misdiagnosis) be regarded as of such

⁶⁰ *Ibid.*:

When the risk is well known, ideally expressed as a prevalence, there is no role for the PP: the appropriate approach here is evaluation of the risk/benefit ratio. When the risk is unclear, the PP is similar to reversal of the burden of proof and consequently requires an assessment by “experts” designated by the authorities.

⁶¹ *Ibid.*, p.320.

⁶² (*Supra*) With the possible exception of diagnoses such as schizophrenia because of the severity of the possible consequences of such diagnoses.

⁶³ See Chapter 4.

⁶⁴ An analogy might be drawn to the official response to reports of police corruption, namely that these are isolated instances [*e.g.* lone ‘*bad apples*’] and, in the absence of clear evidence to the contrary, should be regarded as not representative of the police service.

⁶⁵ See Chapter 4.

a limited provenance as to be of no relevance in the search for global estimates of psychiatric misdiagnosis?

A choice between some such alternatives cannot be avoided and, furthermore, the choice actually made is of fundamental importance not only to an ethical evaluation of coercive psychiatry, but to the practice of psychiatry itself; consider the example given by Witztum (1995b):⁶⁶ the five separate psychiatric teams that reviewed A's earlier diagnosis of schizophrenia had available to them the choice of at least two default presumptions:

(i) that in the absence of clear evidence that the psychiatrist who made the original diagnosis of schizophrenia had made any other erroneous diagnoses, it should be assumed that his diagnosis of A was correct; or,

(ii) that the original diagnosis of schizophrenia may have been mistaken (on the basis that some psychiatric diagnoses are mistaken) and A's case should be examined without any prior assumption that the original diagnosis was correct.

The choice of default presumption clearly influences, if not determines, the resulting decision.

It is not possible to avoid making a choice between such default presumptions;⁶⁷ but it is possible to call on the Precautionary Principle for assistance in the making of the appropriate choice.

Clinical psychiatrists would doubtlessly urge that the rate of coercive interventions grounded in a psychiatric misdiagnosis be regarded as minimal in the absence of evidence to the contrary. The Precautionary Principle, however, would urge that the burden of proof be reversed and that in relation to assessing risk, the risk of psychiatric misdiagnosis as evidenced by the limited studies available, should be regarded as indicative of the general risk of psychiatric misdiagnosis (and of the level of coercive psychiatric interventions grounded in a misdiagnosis) until the contrary is clearly shown. Because coercive psychiatric interventions have potentially severe or irreversible outcomes for the subject, the appropriate course of action is to err on the side of caution;⁶⁸ in particular – and despite urgings to the contrary⁶⁹ – there is no medical duty 'to act'. This is more emphatically the case in relation to coercive

⁶⁶ *Ibid.*

⁶⁷ To pretend not to choose is to permit the *status quo* to continue unscrutinised; Lord Hoffman, made a similar point in *Airedale N.H.S. Trust v Bland* [1993], p.828: "One way or the other a choice is being made."

⁶⁸ Chaudry (2008).

⁶⁹ See, for example, ter Meulen (2005) (*supra*) and his suggestion that: "... in clinical practice there is a duty to act. Physicians have an obligation to do good to their patients ..."

psychiatry where precipitous intervention can (as in Manweiler's case⁷⁰) be destructive of the personhood of the subject.

Section E: The development of the revised argument in subsequent chapters

The argument will be developed in the following steps:

Step 1: The psychiatric usage of the term 'irrational' will be examined in Chapters 2 and 3.

a. if this is found to be tightly circumscribed and precise then it is possible that L_2 is determinable;

i. Because L_2 is not open to independent verification⁷¹ it is necessary to determine whether the psychiatric assessment of irrationality can be taken as reliable; this determination is dependant on a review of psychiatric reliability based on the results of Steps 2b, 3b and 4b below.⁷²

If these indicate a high level of reliability, then L_2 (if determined) can be taken to be reliable.

If not, then L_2 cannot be taken as reliable and, even if determined, is of little use to the subsequent analysis.

b. if this is found to be imprecise then the attempt to determine L_2 must be forgone; this in turn removes the necessity for determining L_1 (*i.e.* the level of irrationality that would justify, philosophically, a finding that personhood was endangered).

Step 2: Problematic aspects of psychiatric diagnosis are examined in Chapter 4 with a view to determining:

- a. the rate of psychiatric misdiagnosis,
- b. whether this rate of misdiagnosis is fully acknowledged in clinical psychiatric practice.

Step 3: Problematic aspects of psychiatric treatment are examined in Chapter 5 (and Appendix I and K) with a view to examining:

⁷⁰ See Appendix H.

⁷¹ The psychiatric ascription of (degrees of) irrationality to a subject is, in general, not open to independent verification. (See *supra*).

⁷² In the manner outlined by Tables 1-1 and 1-2 (*supra*).

- a. (i) the soundness of the evidence base for some standard psychiatric treatments;
- (ii) the extent of iatrogenic harm caused by psychiatric treatment.
- b. (i) whether any deficiencies in the evidence base for these standard psychiatric treatments are fully acknowledged in clinical psychiatric practice;
- (ii) whether the level of iatrogenic harm [a(ii) *supra*] is fully acknowledged in clinical psychiatric practice.

Step 4: Problematic aspects of psychiatric assessment of dangerousness are examined in Chapter 6 with a view to determining:

- a. the error rate in psychiatric assessments of dangerousness,
- b. whether this level of error is fully acknowledged in clinical psychiatric practice.

Step 5: The effects of coercive psychiatric intervention on the personhood of a subject are examined in Chapter 7 with a view to determining:

- a. The possibility that such an intervention can be such as to effectively destroy or grievously diminish the personhood of a subject [*i.e.* is a radical intervention].
- b. whether this possibility is fully acknowledged in clinical psychiatric practice.

Step 6: From the results obtained in Chapters 2 – 7 and relying on the Precautionary Principle, conclusions are drawn concerning firstly, the *Stage 1* and secondly, the *Stage 2 and 3* arguments.

Chapter 2: The psychiatric usage of the term 'irrational' (I): General

You remind me of someone who is looking through a closed window and cannot explain to himself the strange movements of a passer-by. He doesn't know what kind of a storm is raging outside and that this person is perhaps only with great effort keeping himself on his feet.

Remarks made by Wittgenstein to his sister Hermine.¹

The goal of this and the following chapter, is to examine the psychiatric usage of the term 'irrational' with a view to determining:

Question 1: whether the usage manifests precision and deliberation or, on the contrary, is loose and vague;²

Question 2: whether (as judged from the perspective of clinical psychiatric practice) the level of irrationality that is deemed sufficient to participate a coercive intervention, is capable of being estimated and, if so, to attempt its estimation;

Question 3: whether psychiatric assessments of irrationality are reliable.³

The focus of this chapter is to review the psychiatric usage of the term 'irrational' (excluding the term 'delusion'). The psychiatric concept of delusion and its relationship to irrationality is the focus of Chapter 3.

An example of the psychiatric assessment of irrationality is first discussed [Section A]. This case is of especial interest in that it concerned a dispute between a subject's psychiatrists and her non-psychiatric medical doctors concerning whether she was, or was not, rational. The psychiatrists argued that she was not and that, accordingly, she should be the subject of a coercive psychiatric intervention. In that the dispute was public and conducted within the columns of a medical journal – and thus open to the review of their professional colleagues – the psychiatrists must be assumed to have drafted their comments in a deliberative manner giving even greater attention to

¹ See Malcolm (1981), p.16.

² This is the irrationality usage review which was discussed in Chapter 1.

³ This is the reliability review which was discussed in Chapter 1.

Strictly speaking, two subsidiary questions should be distinguished:

- are psychiatric assessments of irrationality reliable when compared with third-party independent assessments of irrationality? [see Ribeiro (1994) *supra*]
- does a scrutiny of the reliability of psychiatric assessments (other than that of irrationality) suggest that the psychiatric assessment of irrationality should be regarded as being reliable?

linguistic precision and logical rigor than might be expected in the less formal environment of a clinical assessment where it might not be subjected to such critical scrutiny. The discussion of this case leads to the tentative conclusion that the psychiatric usage of the term ‘irrational’ may be something of a chameleon, readily adapting to fit its current environment and thus difficult to capture.

In an attempt to determine the correctness of this tentative conclusion, the usage of the term ‘irrationality’ as found in medical and psychiatric journals, textbooks and diagnostic manuals is examined [*Section B*]. The chapter conclusions are set out in *Section C*.

Section A: The Amy case⁴

This case concerns a 77-year-old woman, Amy, who was diagnosed as having lymphoma and who had refused medical treatment. Having put her affairs in order, she attempted to kill herself by drowning. She failed, was hospitalised, but later (on release from hospital) she was successful in her attempts.

Her hospital physician, a Dr. Cameron, subsequently wrote an article⁵ paying tribute to his patient both as a person and in thanks for what the experience of treating her, had taught him. In the course of the article he described the conflicting responses which Amy had elicited from the various medical professionals who had dealt with her case. He focussed especially on the disagreements between the (non-psychiatric) medical specialists – who believed that Amy was rational and that she should not be subjected to forcible psychiatric intervention – and the psychiatric and social work team who believed that she was irrational, that she was mentally ill and that she should be committed to a mental hospital for treatment. This article brought swift rejoinders from Drs. Watler⁶ and Gervais⁷ – the psychiatrists who had been involved in Amy’s case; to which Dr. Cameron responded.⁸

In defence of their diagnosis, the psychiatrists commented, *inter alia*, that:

(i): “... *her habit of speaking tangentially was evidence of mental illness.*”⁹

(ii): “*There is no evidence that patients with serious medical illnesses "rationally" choose to die.*”¹⁰

⁴ This case is discussed more fully in Appendix C.

⁵ Cameron (1997a).

⁶ Watler (1997).

⁷ Gervais (1997).

⁸ Cameron (1997b).

⁹ Watler (1997).

¹⁰ *Ibid.*

(iii): *“In psychiatric terms, this woman was showing signs of grandiosity she would be the one who decided when to live and when to die, and in a way she would act like God. This, to me, is manic denial.”*¹¹

(iv): *“That Amy's clinicians could not agree on the presence of a mental disorder is precisely the reason for detaining high-risk patients for further evaluation.”*¹²

[This quotation exemplifies the problem concerning default presumptions adverted to in Chapter 1.]

This case highlights the paucity of the evidential base on which a finding of irrationality may be based; indeed one of Amy's physicians: *“... noted wryly that the current test of rationality was often concurrence with the opinions of one's physician.”*¹³

A defence put forward by the psychiatrist Gervais is worthy of special note. He had argued to the effect that even though Amy stated that she did not want treatment, she 'really' did and this would have been obvious had she been listened to with the *“third ear”*.¹⁴ To imagine this argument being made by one accused of, for example, rape, is sufficient to demonstrate its folly. To imagine it being made by one charged with determining the rationality of another, is unsettling.

The Amy case is discussed in more detail in Appendix C where the conclusion is drawn that the widespread use of psychiatric labels by the psychiatrists and psychiatric social workers involved showed little awareness of the potency of these terms and of the serious consequences that may flow from their inappropriate use. It is also concluded that, in the instant case, the psychiatric usage of terms such as 'irrational' so lacked precision as to merit the description 'cavalier'.

It is of interest to note that the medical ethicist Paul Appelbaum based an analysis of competence to consent to treatment, on a vignette¹⁵ which shares marked similarities with the Amy case; his conclusions are not dissimilar from those of Amy's psychiatrists

¹¹ Gervais (1997).

¹² Watler (1997).

¹³ Cameron (1997a).

¹⁴ Gervais (1997): *“She was an intelligent, articulate person who talked in an apparently logical way and was listened to in a similar logical way, but she was certainly not listened to with the “third ear.”*”

¹⁵ Appelbaum (2007), p.1834:

A 75-year-old woman with type 2 diabetes mellitus and peripheral vascular disease is admitted with a gangrenous ulcer of the plantar aspect of her left foot. A surgical consultation results in a recommendation for a below-the-knee amputation, but the patient declines the procedure on the grounds that she has lived long enough and wants to die with her body intact. Her internist, who has known her for 15 years, is concerned that she has been increasingly confused over the past year and now appears to be depressed. How should her physician determine whether her decision is a competent one?

especially in the insistence that in order to establish competence, the subject must have exhibited a 'rational' assessment of the relative benefits and risks of treatment.¹⁶

This contention that the refusal of consent must be rational is incompatible with decisions laid down by many legal authorities and by the Irish and US courts.

The Irish Supreme Court, for example, has declared:

The consent ... is not necessarily a decision based on medical considerations ... Such reasons may not be viewed as good medical reasons, or reasons most citizens would regard as rational.¹⁷

The attitude of the US courts is similar¹⁸ and is well exemplified by the case of an asthmatic patient who was subjected to forcible treatment [Annas (1999)]; this case is discussed in Chapter 7.

To insist on the ability to give rational reasons for the refusal of treatment, as a test of competence (as distinct from insisting that the reasons for refusal must be rational if the refusal is to be accepted) would appear to be a distinction without a difference and would effectively circumvent the legal authorities.

Section B: Journals, textbooks and diagnostic manuals

B.1: Medical and Psychiatric journals

Three types of journals were examined: psychiatry journals; philosophy of psychiatry journals; medical journals.

Psychiatry Journals

Searches for occurrences of the term 'irrational'¹⁹ were conducted²⁰ in journals such as the *British Journal of Psychiatry*²¹ and the *American Journal of Psychiatry*²² whose

¹⁶ *Ibid.* p.1838:

To the extent that the patient described in the vignette can clearly communicate her decisions, understands the information about her condition, appreciates the consequences of her choices (especially the likelihood of death if she forgoes amputation), and can weigh the relative risks and benefits of the options, she should be considered competent to make a treatment decision. Given the life-and-death nature of her choice, however, a relatively high level of performance with respect to the relevant criteria should be required ...

¹⁷ *Per Denham J., In the Matter of a Ward of Court* (1995), p.454.

¹⁸ On the situation under US law see, for example, Szasz (2000), p.13:

... an opinion, handed down by Chief Justice ... Warren Burger in 1964, declaring that the right to be let alone attaches as well to the "irrational" decisions of "irrational" patients. In a landmark decision concerning the constitutionality of letting Jehovah's Witnesses reject life-saving blood transfusion, Burger cited Brandeis's famous admonition and then added: "*Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to sensible beliefs, valid thoughts, reasonable emotions, or well-founded sensations. ...*"

¹⁹ Including the term 'irrationality'.

²⁰ The searches were conducted between 8th and 14th December 2009.

²¹ Including all Royal College of Psychiatry journals comprising, *inter alia*, '*The British Journal of Psychiatry*', '*Advances in Psychiatric Treatment*' and the '*Psychiatric Bulletin*'.

main emphasis is on clinical psychiatric practice. Because these searches extended over the life of the journals (c. 150 years) the number of results would have proved unmanageable if full-text searches had been made,²³ accordingly searches were limited to occurrences within the article title or abstract as these might be expected to exhibit a greater precision than occurrences of the term in the main body of an article.

The *British Journal of Psychiatry* search for occurrences between October 1855 and December 2009, yielded 6 results.

The *American Journal of Psychiatry* search for occurrences between June 1844 and June 2007, yielded 42 results.

Philosophy of Psychiatry Journals

Searches were also made in the journal *Philosophy, Psychiatry, & Psychology* but – in that this is a journal of philosophy – I considered that a ‘Full Text’ search would be more informative than a ‘Title/Abstract’ search. For reasons of manageability, this text search was restricted to the period of five years, 1996 to 2000 (c. 30% of all articles ever published in the journal). This search yielded 60 results.

Medical Journals

Searches were also made of some general medical journals: *Medline*, the *Journal of the American Medical Association* and the *New England Journal of Medicine*. Because these journals cover medical specialities other than psychiatry it was necessary to include the term ‘psychiatry’ as an additional search term.

The *New England Journal of Medicine* yielded so few results that a full-text search was feasible; title/abstract searches were conducted for *Medline* and for the *Journal of the American Medical Association*.

The *Medline* search for occurrences in articles published *post-1976*, yielded 19 results.

The *Journal of the American Medical Association* search for occurrences in articles published between July 1983 and December 2009 yielded 21 results.

The *New England Journal of Medicine* search for occurrences in articles published between December 1993 and December 2009, yielded 10 results.

The smallest set of search results (6) was for the *British Journal of Psychiatry* and – in order to convey a ‘flavour’ of the general results – this complete set is listed in Appendix N, Subsection N–1.

²² Including its associated journals comprising, *inter alia*, ‘*Academic Psychiatry*’, ‘*American Journal of Psychiatry*’, ‘*Psychiatric Services*’ and ‘*Psychiatric News*’.

²³ For example, a full text search of the *American Journal of Psychiatry* would have yielded 888 results.

In total, 181 results were retrieved. A database was designed to enable the sorting and analysis of these results by:

- categorisation of the context within which the term ‘irrational’ occurred;
- ranking of whether the usage indicated precision and rigour or, on the contrary, was colloquial;
- classification as to whether coercive intervention was contemplated.

The results of the analysis are given in Appendix N, Subsection N-2.

Some conclusions drawn from the analysis undertaken in Appendix N are given in the following subsection.

B.1.1. Conclusions on the analysis of journal search results.

As mentioned in Appendix N, the search results from the *British Journal of Psychiatry* (which is the main UK journal dealing with clinical psychiatry) provided scant evidence that the term ‘irrational’ was being used in a precise manner. As might be expected, the usage in journals such as *Philosophy, Psychiatry, & Psychology* was more nuanced but the context contemplated by the questions posed at the beginning of this chapter was that of clinical psychiatry rather than the philosophy of psychiatry. In an effort to determine whether the more precise usages as detailed in Table N-2 of Appendix N related to philosophical or clinical psychiatry, the results from philosophical journals have been filtered out in the following table:

<i>Precision</i>	<i>All journals</i>	<i>Clinical journals</i>
***	15	6
****	16	1
*****	3	0
<i>Total:</i>	34 (19% of total of 181)	7 (5.7% of total of 121)

Table 2-1: Analysis of more precise usages by journal type

These results of this analysis enable the conclusion to be drawn that, in relation to clinical psychiatric practice, not only is the journal usage of the term ‘irrational’ generally not used with any degree of precision but its usage is essentially colloquial.

In the course of the above analysis some themes that had been expressed in the Amy case (*supra*) re-emerged:²⁴

²⁴ All the quotations that follow are from journals of applied philosophy: Reznek (1998) is from the *History and Philosophy of the Life Sciences* and all others are from *Philosophy, Psychiatry, & Psychology*.

- the language of paternalism:

Example (i): ... if we start to evaluate the rationality of preferences and give weight to unexpressed preferences, we risk violating the patient's autonomy, but if we do not, we risk abandoning patients to occurrent irrationality.²⁵

Example (ii): ... If the patient is capable of rational thought and decision, then he is allowed his autonomy. If he is irrational, then the doctor is allowed, professionally and ethically, to over-ride his autonomy.²⁶

- scepticism as to the psychiatric meaning of 'irrational':

Example (i): ... in a dialogue between a patient and a psychiatrist, the psychiatrist's judgment of what is rational *a priori* overrides the patient's judgment of it. A psychiatrist could hardly conclude that the choice a patient makes with which he concurs is irrational. ... Physicians receive no training and possess no expertise in separating rational choices from irrational choices ...²⁷

Example (ii): But the concept of rationality is immensely complex and difficult to spell out. Thus the abuse of psychiatry can now be explained as arising from abuse of the concept of rationality, from finding "irrational," in a way that is constitutive of mental illness, those who simply fail to conform adequately to society's norms.²⁸

To conclude this section, one result²⁹ is especially notable both because of the eminence of its author, Professor Savulescu,³⁰ and because of the importance of some of the points that he makes, to the relationship between 'irrationality' and 'delusion' (which is the theme of the following chapter).

Savulescu argued that physicians " ... *should not abandon their patients to irrationality. They should help their patients to deliberate more effectively and to care more about thinking rationally.*"³¹ He then seeks to illustrate his argument in the context of a Jehovah's Witness [JW] refusing life-saving blood transfusions:

We believe that the beliefs of JWs are irrational. ... For argument's sake, we will accept theism. However, the vast majority of those in the Judaeo-Christian tradition have not interpreted these passages from *The Bible* as proscribing blood transfusions. The beliefs of JWs are irrational on at least two counts: their particular beliefs are not responsive to evidence nor are their interpretations of Biblical text consistent.³²

Savulescu's argument is of interest firstly because of the weight he gives to the fact that the views are not shared by the majority – *i.e.* are not orthodox – and

²⁵ Savulescu & Dickenson (1998b), p.264.

²⁶ Hinshelwood (1997), p.125.

²⁷ Szasz (2000), p.14.

²⁸ Megone (1998), p.199.

²⁹ Savulescu & Momeyer (1997).

³⁰ Savulescu holds the Chair in Practical Ethics at the University of Oxford and is also a medical doctor.

³¹ *Op. cit.*, p.282.

³² *Op. cit.*, p.284.

secondly, his unquestioning belief in the rationality of doctors.

As will be shown in Chapter 3, the psychiatric concept of delusion privileges orthodox opinions and their use as a benchmark of rationality. To illustrate the problems engendered by cleaving so closely to such an approach it is sufficient at this stage, to mention that – as happened in the former USSR – it carries the implication that political dissidents, *ipso facto*, become ‘irrational’.

Savulescu pulls back from the conclusion that irrationality justifies the overruling of a patient, citing a number of reasons one of which is that:

... requiring that choice be grounded on rational beliefs before it is respected is fraught with dangers. Those who claim to know Truth with certainty are at least as dangerous as those who claim to know Right and Good with certainty.³³

As will be suggested in Chapter 3, many psychiatrists appear to show no such reluctance.

The second point – which suggests that doctors embody the very touchstone of rationality – may be contrasted with the findings summarised by Sutherland who devotes a chapter of his book *Irrationality*³⁴ to discussing the prevalence of poor reasoning skills in the medical profession, their reliance on intuitive judgements and their poor understanding of probability. These latter assume a heightened importance in clinical psychiatry because:

- the unreliability of intuitive assessments of ‘normalcy’ is relevant to the incidence of psychiatric misdiagnosis especially in relation to delusion; it may go some way towards explaining disparities which have been found to exist in the UK, in the rates of diagnosis of schizophrenia between Blacks and Afro Caribbeans, on the one hand, and Whites.³⁵ [Probabilistic considerations relating to the diagnosis of delusions are explored in Appendix F.]³⁶
- the use of probability judgements in relation to assessments of dangerousness and the high error rate of such assessments. [This problem is explored in Chapter 6 and in Appendix F.]³⁷

³³ *Op. cit.*, p.287.

³⁴ Sutherland (1992).

³⁵ See, for example, Hickling (1999); this and other studies of misdiagnosis are discussed in Chapter 4.

³⁶ Where the conclusions are drawn that:

- Psychiatric assessments based on clinical judgement, of the improbability, or of the pervasiveness, of beliefs should be treated with scepticism unless they can be shown to be grounded in reliable empirical data.

- Psychiatric assessments of the falsity of a belief based solely on the intuitive improbability of the belief, are unreliable.

³⁷ Where amongst the conclusions drawn are:

- The error rate encountered in the psychiatric assessment of dangerousness lies between 80% and 93% depending on the criterion used to define ‘violence’.

Presumptions such as Savulescu's, sustain attitudes such as those noted by Amy's physician (*supra*) that "... the current test of rationality was often concurrence with the opinions of one's physician."³⁸ It is important that they not be uncritically accepted.

B.2: Psychiatric textbooks

Searches were made for occurrences of either 'irrational' or 'irrationality' in a number of textbooks of psychiatry and philosophy of psychiatry:

Psychiatry

- Kaplan & Sadock (2009) [Subsection B.2.1]
- Burton & Fulford (2006) [Subsection B.2.2]

Philosophy of psychiatry

- Fulford (2006) [Subsection B.2.3]
- Thornton (2007b) [Subsection B.2.4]
- Radden (2004) [Subsection B.2.5].

B.2.1: Kaplan & Sadock (2009)

Kaplan & Sadock (2009) is entitled *Comprehensive Textbook of Psychiatry*; it is published in two volumes and comprises 4480 pages.

A full-text search for 'irrationality' yielded no results.

A full text search for 'irrational' yielded 22 results; the most telling of which are:

Example (i): However, another system – the first psychic system in Freud's schema – treated the dream thoughts in a bewildering and irrational manner.³⁹

Example (ii): The "shoulds", or self-imposed demands that they live up to their idealised selves, are irrational and unrelated to the realities of daily life.⁴⁰

Example (iii): Self-defeating behaviors, which may appear irrational from an outside perspective, are often understandable in terms of dynamics of learning.⁴¹

Example (iv): ... both conditions require that an individual recognises the fear as excessive or irrational and either avoids the feared object or situation or endures it with great difficulty.⁴²

Example (v): ... HIV infection ... irrational fears about contracting the disease;⁴³

Example (vi): Clinical exploration of the irrational aspects of patients' internalised antihomosexual attitudes does not always lead to acceptance of one's homosexuality.⁴⁴

- Some eminent academic psychiatrists appear either unwilling or unable to appreciate either the high rate of error involved in psychiatric risk assessment or the extremely serious consequences that may befall anyone subjected to such an erroneous assessment of dangerousness.

³⁸ Cameron (1997a).

³⁹ *Ibid.* p.800.

⁴⁰ *Ibid.* p.862.

⁴¹ *Ibid.* p.873.

⁴² *Ibid.* p.1847.

⁴³ *Ibid.* p.2085.

Kaplan & Sadock's (2009) usage of the term 'irrational' shows little evidence of precision or rigour.

B.2.2: Burton & Fulford (2006)

Burton & Fulford (2006) is entitled *Psychiatry* and is described as a "*clinically focused textbook [which] provides a comprehensive account of psychiatric disorders.*"⁴⁵

A full-text search for 'irrationality' yielded no results.

A full-text search for 'irrational' yielded 5 results all of which concerned phobia and were variants on, for example:

A phobia is defined as a persistent irrational fear that is usually recognised as such and that produces anticipatory anxiety for and avoidance of the feared object, activity or situation.⁴⁶

B.2.3: Fulford (2006)

Fulford (2006) is entitled the *Oxford Textbook of Philosophy of Psychiatry*. A full-text search was not possible but an index search for 'irrational' or 'irrationality' produced no results.

Lest the index was incomplete, an index search for both 'rational' and 'rationality' was made which produced three results:

1. The first was in a discussion concerning consent and referred to the possibility of "rational suicide":

Can we simply assume that Martin is mentally ill because he wants to die? If Martin's desire for death is a consequence, or aspect of mental illness, then he can be treated ... [p.556-7]

2. The second was in a section entitled "*The central role of rationality*" and referred to the philosophy of Dennett and Davidson whose arguments:

... emphasize the constitutive role of rationality for the possession of a mind ... if sound, these arguments also suggest an argument against the reduction of mental states to brain states, ... [p.610]

3. The third concerned the problem of knowledge of other minds:

This turns on the role and nature of rationality in psychological explanation. The basic idea is this: '*in giving a psychological explanation we render the thought or behaviour of the other intelligible, ... [But] To be rational does not guarantee that any specific belief must be true. ... nor could rationality or competence be identified with making the correct application of particular rules of inference.* [p.747-8]

⁴⁴ *Ibid.* p.2087.

⁴⁵ Judges, Royal Society of Medicine and Society of Authors 2007 Book Awards; see: http://www.amazon.co.uk/Psychiatry-Neel-Burton/dp/1405136529/ref=sr_1_1?ie=UTF8&s=books&qid=1261394031&sr=8-1 [accessed: 21 December 2009].

⁴⁶ Burton & Fulford (2006), p.97.

B.2.4: Thornton (2007b)

Thornton (2007b) is entitled *Essential Philosophy of Psychiatry*. A full-text search for occurrences of either ‘irrational’ or ‘irrationality’, yielded no results.

B.2.5: Radden (2004)

Radden (2004) is a collection of essays and is entitled *The Philosophy of Psychiatry: A Companion*.

A full-text search for occurrences of ‘irrational’ yielded 15 results; for ‘irrationality’, yielded a further 17. All of these results occurred in just 4 (of the 30) essays contained in Radden (2004).

(i) Gillett (2004). ‘Cognition: Brain Pain: Psychotic Cognition, Hallucination and Delusions;’⁴⁷ [Subsection B.2.5.1]

(ii) Culver & Gert (2004). ‘Competence’;⁴⁸ [Subsection B.2.5.2]

(iii) Chadwick & Aindow (2004). ‘Treatment and Research Ethics’;⁴⁹ [Subsection B.2.5.3]

(iv) Wilson & Adshead (2004). ‘Criminal Responsibility’.⁵⁰ [Subsection B.2.5.4]

Subsection B.2.5.5 contains some reflections on the various usages.

B.2.5.1: Gillett (2004). ‘Cognition: Brain Pain: Psychotic Cognition, Hallucination and Delusions.’

There were two occurrences of ‘irrational(ity)’:

1. The first discussed psychosis:

The nature of psychotic irrationality and the cognitive dynamics of a psychotic break in the sense of self are both hotly debated. [p.22]

2. The second was in a discussion entitled ‘Paranoid Irrationality’:

In many and diverse ways the normative discursive context in which I operate moderates the beliefs I will accept so that they are reasonable, all things considered, and not just rationally coherent. ... Kant uses the colloquialism “*horse sense*” to indicate the pragmatic reasonableness that we all take for granted and that gives rise to full-blooded science as an intellectual discipline. [p.31]

⁴⁷ Radden (2004), pp.21-35.

⁴⁸ *Ibid.* pp.258-270.

⁴⁹ *Ibid.* pp.282-295.

⁵⁰ *Ibid.* pp.296-311.

B.2.5.2: Culver & Gert (2004). 'Competence'

There were fifteen occurrences of 'irrational(ity)'; the following examples are representative:

Example (i): The woman in Case #1 suffers from a seriously irrational⁵¹ fear of ECT treatment⁵² and the man in Case #2 has a seriously irrational desire to die. Most physicians believe that these patients' refusal should be overruled. [p.262]

Example (ii): For example, the patients in Cases #1 and #2 would be labeled as competent, but their refusals would be regarded as seriously irrational, and on the basis of that serious irrationality it would be ethically justified to overrule them. [p.263-4]

Example (iii): Any account of irrationality to be incorporated into the concept of competence must be such that no decision is regarded as irrational if any significant number of persons would regard that decision as rational. ... This means that no decision based on religious beliefs that are held by a significant number of people will be irrational. [p.264]

B.2.5.3: Chadwick & Aindow (2004). 'Treatment and Research Ethics'

The terms 'Irrational(ity)' occurred in two passages:

1. The first occurrence was:

Lindley ... argues that the mentally disordered person who has irrational beliefs is incapable of making rational decisions about his welfare:

What is special about someone who has radically irrational beliefs of this kind is that he is likely, unwittingly, to get into all kinds of dangers. The person who believes he is indestructible might well walk into the middle of a busy road ... he would not be moved by one's reasoning. [p.284]

2. The second occurrence was:

(p. 286-7) The patient has the capacity but refuses treatment. Some argue that even if a patient is competent to make a specific local decision, this decision should not always be respected – for example, when a decision, although competent, is irrational. For example, they may refuse a treatment because they regard it as a form of torture, punishment, or poison. Harry Lesser argues:

Only if the phobia, or the depression or indecisiveness, is evidently preventing the patient from thinking clearly at all ... is one justified in regarding the preference ... as irrational ... and the patient – however irritating this may be to some doctors – should be considered 'rational until proved irrational.' [p.286-7]

The last quotation appears after a brief – half-page – discussion entitled 'Justification of Compulsory Treatment':

People may be troubled by behavior that appears unusual or bizarre and feel that this constitutes a threat requiring action, even if closer observation of particular situations might suggest limited potential for harm by the patient. Consequently,

⁵¹ Double underlining is used to indicate an explicit acknowledgement that levels of irrationality exist.

⁵² See the comments by Chadwick & Aindow *infra* who doubt whether a refusal to consent to ECT should be considered to be irrational.

practitioners may then feel themselves charged with intervening and offering treatment. While this may be argued from the perspective of a duty of care on the part of a practitioner, it may seem more akin to a duty to protect the interests of other relevant parties ... before the interests of the patient. The practitioner may be in a position of “*jailer*” as much as caregiver ...⁵³

B.2.5.4: Wilson & Adshead (2004). ‘Criminal Responsibility’

There were five occurrences of ‘irrational(ity)’, the most relevant were:

Example (i): The law treats the mentally disordered as being irrational. [p.297]

Example (ii): Irrationality is what matters, Morse (1999) argues. However, *pace* Morse, causation is not totally beside the point, as illustrated by an example from Kenny (1986) of an academic who is suffering from paranoid delusions that his colleagues are persecuting him and who decides to poison his mother-in-law to inherit her fortune. It is hard to see why one set of crazy beliefs that make him irrational should excuse an apparently calculated motive. [p.298]

B.2.5.5: Some reflections on the usages in Radden (2004)

The usages in Radden (2004) were perhaps the most precise of those uncovered in the searches (with some acknowledging possible gradations of irrationality) yet some⁵⁴ by equating rationality with orthodoxy⁵⁵ in effect identify ‘the man on the Clapham omnibus’ as the touchstone of rationality. As adverted to earlier, a possible consequence of such an analysis is that solely by virtue of the fact that the man on the Moscow omnibus was most unlikely to share the views of Soviet dissidents, these dissidents were ‘irrational’ and hence became suitable candidates for (psychiatric) treatment. The fact that such a problem has not been adverted to in Radden is eloquent testimony to the inadequacy of the analysis of the concept of irrationality. Such a conclusion is also born out by contrasting Culver & Gert’s Case #1 (*supra*) concerning the woman who “*suffers from a seriously irrational fear of ECT*” and some comments by Chadwick & Aindow:

While there are clearly ethical issues associated with the potential effects of drug therapy... there are several objections, beyond physical harm, that might be made to ECT: for example, as an assault on the dignity of the person, it is wrong in itself (Clarke 1995). Nevertheless, supporters of ECT have defended it for consequentialist reasons, on the grounds that it “works.” The problem with this argument is twofold: first, there are also negative consequences to be considered, such as memory impairment; second, in an era of evidence based medicine, claims about the efficacy of ECT are insufficiently supported. In light of these points, it may be questioned whether it is irrational to refuse this treatment. This is

⁵³ *Ibid.* p.286.

⁵⁴ For example, Gillett: “the *sensus communis*”, “*horse sense*”; Culver & Gert: “*no decision based on religious beliefs that are held by a significant number of people will be irrational*”.

⁵⁵ The term ‘orthodox’ is used here and in the following chapters to describe beliefs which are widely accepted in a society or social group; such beliefs contrast with those which are shared by only a small minority and are termed ‘unorthodox’.

important in light of a further objection to ECT that relates to the wider context of delivery of treatment: What does it mean to say it “works”?⁵⁶

The apparent conflating of dangerousness and mental illness – see Lindley (*supra*) – is to be regretted in that it precludes a rigorous analysis of dangerousness and its possible links to mental illness. [The disentangling of these issues is the focus of Chapter 6.]

It is worthy of note that, of the thirty essays in Radden, the brief remarks by Chadwick & Aindow (*supra*) comprise the only mention of what is ethically the most problematic aspect of psychiatry, namely its ability to invoke compulsion.

B.3: Psychiatric diagnostic manuals

The psychiatric diagnostic manuals in current use are:

- the *Diagnostic and Statistical Manual of Mental Disorders* which is now in its fourth revision [*DSM-IV* (1994)] and has had a subsequent text revision [*DSM-IV-TR* (2000)]⁵⁷; it is published by the American Psychiatric Association.
- the *ICD-10 Classification of Mental and Behavioural Disorders*.⁵⁸

It is published by the World Health Organisation in two editions: one with a subtitle *Clinical descriptions and diagnostic guidelines*; the second is entitled *Diagnostic criteria for research*.

Reports of searches of the *DSM-IV-TR* (2000) for occurrences of ‘irrational’ or ‘irrationality’ are given in *Subsection B.3.1*; reports of similar searches of the *ICD-10* are given in *Subsection B.3.2*.

B.3.1: DSM-IV-TR (2000)

An index search for occurrences of either ‘irrational’ or ‘irrationality’ yielded no results; however a full-text digital search yielded 4 results:

1. The first occurrence is in the Introduction:

Mental disorders have also been defined by a variety of concepts (*e.g.*, distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions. [p.xxx]

⁵⁶ Radden (2004), p.287. The question posed at the end of this quotation is central to the issues discussed in Chapter 5 (*infra*).

The 2011 decision by the FDA to investigate ECT has highlighted the dearth of current research on its use, efficacy or safety [see footnote in Conclusions: Proposals – Psychiatry]. See also Chapters 5 and 7.

⁵⁷ Cited as *DSM-IV-TR* (2000).

⁵⁸ Cited as *ICD-10*.

2. The second occurrence is in a discussion of phobias:

Specific Phobias: ... In contrast, individuals with irrational fears of blood injury, medical procedures, and medical settings may be less likely to seek help for phobias.

3. The third occurrence is in a glossary of ‘Culture-Bound Syndromes’:

pibloktoq: An abrupt dissociative episode accompanied by extreme excitement ... frequently followed by convulsive seizures and coma lasting up to 12 hours. This is observed primarily in arctic and subarctic Eskimo communities ... During the attack the individual may tear off his clothing, break furniture, shout obscenities, eat feces, flee from protective shelters, or perform other irrational or dangerous acts. [p.901]

4. the final occurrence is in an appendix:

Phobia: A persistent irrational fear of a specific object, activity, or situation ... that results in a compelling desire to avoid it... [Appendix C: Glossary of Technical Terms]

A digital full-text search was also made⁵⁹ in all other publications of the American Psychiatric Association [the publishers of the *DSM-IV-TR* (2000)];

- a search for occurrences of ‘irrational(ity)’ yielded 6 results of which only one had any relevance; it was entitled ‘*Discrimination against Persons with Previous Psychiatric Treatment.*’
- a search for occurrences of ‘irrational(ity)’ yielded 12 results.

Of those 8 that had some relevance to clinical psychiatry:

- 3 concerned the execution of mentally ill prisoners;
- 1 concerned medication in nursing homes;
- 1 concerned child mental health;
- 1 concerned substance abuse;
- 1 concerned HIV;
- 1 concerned anxiety disorder.

B.3.2: ICD-10

Full-text digital search were made of both the *ICD-10: Clinical descriptions and diagnostic guidelines* and the *ICD-10: Diagnostic criteria for research*.

ICD-10: Clinical descriptions and diagnostic guidelines

A search for ‘irrational(ity)’ yielded no results; that for ‘rational(ity)’ yielded two results:

1. The first was in relation to specifying the diagnostic criteria for “*Dissocial personality disorder*”:

⁵⁹ Search conducted on 19th December 2009.

... (f) marked proneness to blame others, or to offer plausible rationalizations, for the behaviour that has brought the patient into conflict with society.

2. The second concerned the diagnostic criteria for “*Habit and impulse disorders*”:

This category includes certain behavioural disorders that are not classifiable under other rubrics. They are characterized by repeated acts that have no clear rational motivation and that generally harm the patient's own interests and those of other people.

ICD-10: Diagnostic criteria for research

A search for ‘irrational(ity)’ yielded no results; that for ‘rational(ity)’ yielded one result: ‘*Dissocial personality disorder.*’ [See *supra*]

The paucity of these results is difficult to reconcile with Fulford’s (2006) assertion (*supra*) on the centrality of the role played by rationality in psychiatry.

Section C: Conclusions

The term ‘negligence’ as found in law journals, court reports and legal textbooks is generally accompanied by well recognised distinctions between, for example, ‘negligence’, ‘gross negligence’ and ‘recklessness’; in consequences the gradations of negligence are capable of precise description. This generally permits the level of negligence which might attract the attention of the criminal law (*e.g.* ‘recklessness’) to be distinguished from lesser forms.

In planning the analysis of the psychiatric usage of ‘irrational’, the initial hope was it might resemble the legal usage of the term ‘negligent’ and that a perusal of the journal search results would enable the various meanings of the term ‘irrational’ to emerge which would, in turn, have permitted a classification of meanings with distinctions rigorously drawn. It was further hoped that the usage associated with coercive interventions could be clearly identified and differentiated from other, lesser, forms.

The hopes have clearly not been fulfilled and the conclusion drawn earlier in relation to journal usage must be extended to diagnostic manuals and textbooks of psychiatry [with the possible exception of textbooks on the philosophy of psychiatry such as Radden (2004)]⁶⁰ and can be summarised in the conclusion that the psychiatric use of the term ‘irrationality’ (in contexts other than delusion) is informal and so lacking in precision that no particular meaning emerges which corresponds to those cases which are deemed eligible for coercive intervention.

⁶⁰ The questions posed at the beginning of this chapter related to usage in clinical psychiatry rather than the philosophy of psychiatry

This conclusion is echoed by Culver & Gert (1982) who, in their '*Philosophy in Medicine: Conceptual and Ethical Issues in Medicine and Psychiatry*', state:

“Rationality” and “irrationality” are among the most important concepts in both psychiatry and philosophy. Yet psychiatrists have generally not presented any explicit account of them and have often not distinguished these concepts from related ones like “mental health” and “mental illness.”⁶¹

The following questions were posed at the beginning of this chapter in relation to the psychiatric usage of ‘irrational’ (in contexts other than discussions of delusion):

Question 1: Whether the usage manifests precision and deliberation or, on the contrary, is loose and vague;

Question 2: Whether (as judged from the perspective of clinical psychiatric practice) the level of irrationality that is deemed sufficient to participate a coercive intervention, is capable of being estimated and, if so, to attempt its estimation;

Question 3: Whether psychiatric assessments of irrationality, when compared with third-party independent assessments, are reliable.

The answer to the first is that the usage is generally vague; to the second, in that levels of irrationality were seldom identified, the level that precipitates a coercive intervention cannot be identified; to the third, the usage is not sufficiently precise as to permit comparisons with independent assessments.

These conclusion relate to the psychiatric use of ‘irrationality’ in cases other than delusion; the relationship between the psychiatric concept of irrationality and that of delusion, is the theme of the following chapter.

⁶¹ Culver & Gert (1982), p.20.

Chapter 3: The psychiatric usage of the term 'irrational' (II): Delusion

“Your delusion is total, and all the more dangerous and incurable in that you speak just like a person who is fully in possession of her reason.”

Spoken to Hersilie Rouy by her doctor.¹

To be deluded (*i.e.* to have ‘delusions’) is to the layperson and to the philosopher, the very epitome of being irrational; this is a perception that is, to a degree, also shared by psychiatry.² Furthermore the concept of delusion is central to psychiatry: Karl Jaspers, for example, held that delusion is the “*basic characteristic of madness*”.³

Of all the psychiatric conditions which might warrant a coercive psychiatric intervention – and which, in consequence, might be philosophically justified by a breach of the rationality condition of personhood – delusion is preeminent because its connection with irrationality appears so especially intimate and transparent.

Accordingly the fact that psychiatrists might seek to justify a coercive psychiatric intervention on the grounds that a subject is deluded, in circumstances where it is doubtful that the subject manifests *any* irrationality – let alone irrationality of a degree sufficient to justify a diminution of personhood – is, to say the least, surprising. In the following paragraphs, I will sketch how such cases can, and do, occur and, in doing so, explain the structure to be adopted later in this chapter in discussing delusion.

The Oxford English dictionary defines ‘delusion’ as “*A false impression or opinion, esp. as a symptom of mental illness.*”⁴

¹ Masson (1993), p.54, quoting from Rouy, H. (1883). *Memoirs Of A Madwoman*. Paris: Paul Ollendorff. Masson (who is an Honorary Fellow in the Department of Philosophy at the University of Auckland) believes Rouy’s book to be “... *the single most important document of the social history of madness in the nineteenth century.*” (p.52)

² In that the terms ‘rational’ and ‘delusional’ are necessarily incompatible though the term ‘rational delusion’ - which one encounters occasionally - might appear to offer a counterexample. This latter term has sometimes been used to describe a delusion which has a strong inner coherence which presents no internal contradictions and which is such that, once one enters willingly into the territory of the delusion, every objection can be met with a coherent response. It is, I suggest, an inappropriate description for such delusions in that they are not characterised by their rationality but by a strong internal logic within their tightly circumscribed orbit.

Much as a political scientist who was interested in the development of social democracy might assert that “*Sweden is the very epitome of a western social democracy*” – a perception which is not invalidated by the fact that a sociologist might prefer to utilise other concepts in their own analysis of Swedish society; the suggestion that delusions embody the very epitome of irrationality does not preclude the fact that psychiatrists might also find other attributes of delusions – *e.g.* their incorrigibility – of greater use in their analysis of delusion.

³ Jaspers (1997), p.93.

⁴ *New Shorter Oxford English Dictionary* (1997), ‘delusion’:

The *Diagnostic and Statistical Manual of Mental Disorders* defines a ‘delusion’ as being:

A false belief ... that is firmly sustained despite what almost everybody else believes and despite ... incontrovertible and obvious proof or evidence to the contrary ...⁵

Thus both lay and professionals alike would appear to regard ‘falsity’ as an intrinsic characteristic of a delusion. However, as Professor Manfred Spitzer has pointed out, many clinical psychiatrists regard the *DSM-IV-TR* (2000) definition as too onerous because either:

... the criteria of truth or falsity are not applicable to various sorts of statements that the clinician nevertheless wants to subsume under the concept of delusion ... [or] ... in many cases the clinician cannot actually disprove the claims of the patient ... , [or] ... there are delusions that turn out to be true.⁶

In consequence, clinical psychiatrists prefer to use – what, for convenience, I term – ‘*the justifiability criterion*’ (which places the onus on the subject to justify his belief) in place of ‘*the falsity criterion*’ (which places the onus on the clinician to demonstrate the falsity of the belief). In consequence, the fact that a belief is true does not preclude it being classified by a clinical psychiatrist as a ‘delusion’ as the following discussion will show.

In seeking to examine the relationship between ‘delusion’ and ‘irrationality’, I have focused on a particular subset of delusions namely ‘delusions of infidelity’⁷, because:

- (i) a delusion of infidelity may be viewed as paradigmatic of psychotic disorders.⁸
- (ii) of all delusions, delusions of infidelity present a tightly circumscribed problem which is more amenable to philosophical analysis, especially as delusions of infidelity do not necessarily involve any other contentious belief.⁹
- (iii) in that such delusions may be true, they present the philosophically interesting paradox of the ‘true delusion’.¹⁰

(i) The action of deluding or of being deluded; the state of being deluded. LME.

(ii) A false impression or opinion, esp. as a symptom of mental illness. M16.

⁵ *DSM-IV-TR* (2000), p.821; the definition is discussed in more detail in Section B *infra*.

⁶ Spitzer (1990), pp.378-9. [Emphasis in original].

⁷ Also known as ‘*Morbid Jealousy*’ or ‘*The Othello Syndrome*’.

⁸ Fulford (2006), p.8.

⁹ Enoch (1967), p.47:

I have now in an asylum two quite rational-looking men, whose chief delusion is that their wives, both women of undoubted good character, had been unfaithful to them. Keep them off that subject and they are rational. But on that subject they are utterly delusional and insane.

¹⁰ The concept of a ‘true delusion’ appears paradoxical and might suggest that much as ‘schizophrenia’ has a meaning in colloquial speech different from that in the professional literature, ‘delusion’ might also have a technical meaning which would lessen the apparent paradox; this is not the case. The technical meaning as specified in the *DSM* requires that a delusion be false.

Writing on ‘delusions of infidelity’, Kingham & Gordon (2004) state:

It is noteworthy that individuals may suffer from morbid jealousy even when their partner is being unfaithful, provided that the evidence that they cite for unfaithfulness is incorrect and the response to such evidence on the part of the accuser is excessive or irrational.¹¹

Fulford (2006) gives an example:

Mr O.S. ... Attended general practitioner’s surgery with his wife who was suffering from depression. On questioning, delivered an angry diatribe about his wife being ‘a tart’. Unable to talk about anything else. Offered unlikely evidence (*e.g.* pattern of cars parked in road). Psychiatric referral confirmed diagnosis even though the doctors concerned knew that Mrs. O. was depressed following the break up of an affair.¹²

That a true belief might be classed as a delusion appears to be a contradiction in terms; yet the generality of psychiatrists appear untroubled by this seeming paradox¹³ although some isolated dissenting voices are occasionally raised.¹⁴ The following thought experiment may help elucidate some of the underlying issues.

An imagined scenario:

Imagine a teacher who believed that a colleague was sexually abusing a pupil. The teacher had no evidence that this was so only a deep unshakeable conviction forged from observing supposedly furtive glances, pauses of conversation and similar ‘evidence’. The teacher approached her headmaster with her suspicions; she could offer no evidence that he found convincing but she could not be shaken in her belief.

The headmaster may remain unconvinced and he might well conclude that the teacher was deluded in her beliefs but even if the teacher persisted in her belief a psychiatric diagnosis of delusion – and, *a fortiori*, a coercive psychiatric intervention – would seem inappropriate.

Next imagine that the headmaster actually knew that the colleague was sexually abusing the pupil (the colleague had earlier confessed to the headmaster that the allegation was

¹¹ *Op. cit.*, p.207.

The distinction between ‘morbid’ and ‘normal’ jealousy hinges on the meaning of ‘normal’ – a term whose ambiguities will be discussed later in this Chapter.

¹² *Op. cit.*, p.43.

¹³ Jaspers (1997), p.106:

A delusion of jealousy, for instance, may be recognised by its typical characteristics without our needing to know whether the person has genuine ground for his jealousy or not. The delusion does not cease to be a delusion although the spouse of the patient is in fact unfaithful - sometimes only as the result of the delusion.

See also Mullen (1990), p.826:

Another difficulty with the truth criteria is that patients may express beliefs about their partner’s infidelity, expressed in a bizarre and apparently delusional manner, but which are correct in the central assertion.

¹⁴ David (1999) (*infra*).

true) then surely an assertion by the headmaster, that the teacher was deluded could not stand.

Indeed if the headmaster sought to sustain his assertion that the teacher was deluded and on that account sought to discipline the teacher, then any subsequent legal challenge by the teacher would most surely exonerate the teacher and find the headmaster's assertion to be bizarre. A more likely response from the headmaster would be a recognition that the teacher had been unusually perspicuous to notice what others, less observant, had not noticed.

This suggests that the justifiability criterion is an inappropriate substitute for the falsity criterion; its use will be discussed in more detail later in the chapter.

Despite their apparent similarities, the examples of the suspicious teacher and the jealous husband, unfold in radically different ways; can they be distinguished?

Fulford suggests that morbid jealousy is “... *one of the few psychiatric conditions known to be definitely associated with an increased risk of homicide.*”¹⁵ and, if he is correct, this might appear to serve as a distinguishing feature.

Fulford cites a single reference [Enoch (1967)] for his ‘definite’ association between morbid jealousy and homicide, but this reference (as is shown in Chapter 6) does not substantiate any such association; instead it refers to a further study which shares a fault with many other such studies, in that it is based on an erroneous probabilistic analysis which confuses:

- the probability that a jealous individual is dangerous; with
- the probability that a dangerous individual (*e.g.* one convicted of murder) exhibits jealousy.

Such errors are of a level of seriousness such as to render any subsequent analysis almost worthless.¹⁶

Leaving to one side for the moment the truth or otherwise of Fulford's assertion,¹⁷ the supposed ‘dangerousness’ cannot be such as to transform what is a true statement into a delusion (*i.e.* it cannot effect the existence of delusion) thus it cannot serve to

¹⁵ Fulford (1989), p.204.

¹⁶ Such errors are known as ‘base rate errors’; See Chapter 6 and Appendix F for an extended discussion.

¹⁷ The argument being developed in this dissertation comprises:

- a Stage 1 argument (where coercive interventions are justified solely on the interests of the subject);
- Stage 2 and 3 arguments (where coercive interventions are justified on the grounds of the interests of others)

the supposed ‘dangerousness’ of morbid jealousy belongs to the Stage 2 argument and will be discussed in that context in Chapter 6.

distinguish between the teacher who believes (rightly) that a fellow teacher is sexually abusing a student, but who is unable to justify her belief; and a husband who believes (rightly) that his wife is unfaithful but who is unable to justify this belief.¹⁸ It would seem to be the case that either both (or neither) must be classed as delusional; what offends logic is a classification which renders the husband delusional but not the teacher.

This extended preface has been by way of introduction to the complexities inherent in the psychiatric concept of delusion – a concept which less charitable commentators have described as being a “*shambles*.”¹⁹

Chapter Structure

An Irish legal case which concerned an individual who was forcibly committed to a mental hospital on the grounds that he harboured delusions of infidelity, is discussed in Section A. The psychiatric definition of delusion is explored in Section B and some of its more problematic aspects are examined in Section C. The concept of ‘normalcy’ is intimately related to the psychiatric analysis of delusion; it is discussed in Section D.

A problem (‘recovered’ memories of childhood sexual abuse) which bears considerable similarity to that of unjustified beliefs in the sexual infidelity of a spouse, has been discussed in a series of articles²⁰ in the journal *Philosophy, Psychiatry, & Psychology*, by a group of philosophers who appear to see little difficulty in accepting the truth of such beliefs even if these are incapable of being justified; the contrasting philosophical analysis of these two problems raises the question as to whether this constitutes an instance of special pleading [Section E].

If indeed this is the case, it would tend to undermine claims by philosophers to being impartial in their philosophical analysis of psychiatry and suggest that they perceive the role of philosophy as being the buttressing – rather than the critical scrutiny – of the psychiatric *status quo*.²¹

Some conclusions concerning the relationship between irrationality and delusion are drawn in Section F.

The goal of the chapter is to address the following questions:²²

Question 4: Is the psychiatric definition of delusion coherent?

¹⁸ This is not to deny that the consequences appropriate to the differing scenarios, might differ.

¹⁹ See David (1999) (*infra*).

²⁰ Freedman (2007a); Nissim-Sabat (2007); Potter (2007); Lieberman (2007) and Freedman (2007b).

²¹ See Papineau (2006) *infra*.

²² Continuing from *Questions 1, 2 and 3* of Chapter 2.

Question 5: Does the psychiatric diagnosis of a subject as ‘delusional’ necessarily imply that the subject is irrational?

Question 6: Do gradations of delusion correlate with levels of irrationality in such a manner that the gravity of a delusion which is sufficient on its own²³ to (as adjudged by psychiatrists) warrant a coercive intervention, corresponds to a level of irrationality sufficient to put personhood in jeopardy?

Section A: The Blehein Case

In the late 1990s a Mr. Louis Blehein, a teacher who had been involuntarily committed to a mental hospital on the application of his wife, made a number of court applications seeking redress from those who had been instrumental in his committal. In particular, he claimed that the provisions of the Mental Health Acts had not been complied with in that: “neither of the two doctor defendants who were present at the time had examined him.”²⁴ The circumstances underlying the case were set out in decisions of both the High, and Supreme, Courts:

The High Court: ... [Blehein’s wife] went to ... Dr. Murphy, who is the family GP, and claimed that her life was unbearable because of an alleged obsession on the part of the Applicant that she was having affairs with other men. ... Dr. Murphy says that Dr. Kennedy went to the bedroom, conducted an interview with the Applicant and confirmed that, in her view, he was suffering from delusions.²⁵

The Supreme Court: ... [Dr.] Murphy, one of the two doctors who signed the certificate seeking the Applicant’s reception and detention, stated that the Applicant was suffering from serious delusions about his wife’s fidelity and “believes she is having sexual affairs with at least six other men”. The Applicant submitted that the basis upon which Dr. Murphy signed the certificate was that there was no proof that his wife was unfaithful and that therefore his accusations of infidelity were the result of delusions. Prior to his hospitalisation the Applicant had employed private detectives in an effort to establish evidence of his wife’s infidelity.²⁶

Blehein claimed that the work of the detectives had been frustrated by the Gardai and thus he was prevented from establishing the truth of his beliefs and, consequently, of proving that he was not deluded.²⁷ Blehein argued that as the falsity of a belief is a prerequisite to it being classified as a ‘delusion’, he had not been shown to have been delusional; the courts, however, did not address this argument and resolved the case on what were essentially paternalistic grounds implicitly accepting that Blehein was delusional.

²³ That is without recourse to assessments of dangerousness to others.

²⁴ *The Irish Times* (1999). ‘Ruling due on leave to sue over detention in mental hospital’. *The Irish Times*. 2 July.

A similar contention was equally unsuccessful in *Z. v Khattak & Anor.* [2008] (*supra*).

²⁵ *Blehein v Murphy and Others.* (1999).

²⁶ *Blehein v St. John of God Hospital & anor.* (2002). [Emphasis in original].

²⁷ The analogy of an accused who was prevented by the Gardai from establishing the truth of his alibi, is not wholly inappropriate.

In relation to the development of the dissertation argument, the Blehein case is of interest primarily in that it permits the question to be posed as to whether Blehein could be considered to be ‘irrational’ based on the facts as disclosed to the courts. [Subsection A.3]. Before addressing this question, it is necessary to examine whether some of the particulars of Blehein’s belief (*i.e.* “*affairs with at least six other men*”) were crucial to its categorisation as a delusion. [Subsection A.1] A further issue (which I term the ‘*pre-diagnostic decision*’) concerns why a problem which could possibly be viewed as a marital problem and whose locus lay with both parties (with separation as a possible solution), was categorised as a *psychiatric* problem whose locus lay solely with Mr. Blehein. [Subsection A.2]

A.1: “at least six other men”

The Supreme Court appeared to have regarded the suggestion of affairs “*with at least six other men*” as of sufficient importance to merit a direct quotation from the GP’s notes. This may suggest that it was crucial to either the legal or the psychiatric assessment of the case and that had Blehein simply believed his wife to be having an affair with only one other man, he would not have been considered delusional. This is not so²⁸ in that the essential point concerning the clinical diagnosis of delusions of infidelity is the inability of the subject to justify his belief.²⁹

It is also worth considering the possibility that in making his note, Blehein’s GP was making an informal note with no expectation that it might ever feature in legal proceedings. Had, for example, the GP’s question to Blehein been “*With whom do you think that your wife has been unfaithful?*” then a reply such as “*A,B,C,D,E and F are all possibilities*”, might well have been summarised by the GP in the phrase actually used though, it should be stressed, there is no evidence that this was the case. Furthermore, if indeed the note is an accurate summary of Blehein’s belief, the timescale over which he believed these affairs to have been conducted may be considered to be relevant. The scenario of the unfaithful wife who conducted six affairs

²⁸ A case taken by Mr. David Harty, for example, is similar to Blehein’s but with no imputation of multiple affairs. [*The Irish Times*, (2002a). ‘Challenge to detention in psychiatric hospital rejected’. *The Irish Times* 16 April.]

See also: *The Irish Times*, (2002b). ‘Man who claims wife put him in psychiatric hospital to get his money has case adjourned.’ *The Irish Times*. 9 April.

²⁹ Some caveats must be entered at this point: Kingham & Gordon (2004), *infra*, suggest that a belief in multiple affairs (rather than a single affair) is indicative of delusion; secondly, the belief in multiple affairs may have sufficed to elevate the delusion from being a ‘*non-bizarre*’ delusion to being a ‘*bizarre*’ delusion and thus rendered Blehein liable to a diagnosis of schizophrenia. [The criteria for ‘*bizarre delusion*’ are in essence, sufficient to satisfy the *DSM-IV-TR* (2000) ‘*Diagnostic Criteria for Schizophrenia*’ (see B.1 *infra*)].

over ten years is more believable (has, to coin a phrase, more ‘*Literary Truth*’³⁰) than had the affairs occurred over a matter of weeks. These observations are made simply to emphasise the point made in discussing the Amy case³¹, that over-concise statements of facts should be treated with extreme caution in that they may suggest a precision which a fuller account would show to be illusory.

A.2: *Pre-diagnostic decisions.*

The relationship between Blehein and his wife was undoubtedly in difficulties; however, the next step in the analysis of the relationship – *i.e.* placing the locus of the problem in Blehein’s psyche or behaviour and consequently categorising it as a psychiatric problem – is an example of a ‘pre-diagnostic’ decision.³² Such pre-diagnostic decisions seldom³³ appear to warrant the attention that is given to diagnosis but the pre-diagnostic decision may be an even more important source of psychiatric misdiagnosis³⁴ than the actual diagnosis.

A different pre-diagnostic decision – namely that in view of the disharmony between the parties, they should consider a marital separation – might have offered an alternative resolution. Support for such a resolution might have been garnered from the finding³⁵

³⁰ By saying that a character has ‘*Literary Truth*’ I mean that, considered as a fictional character portrayed in some work of literature, the character ‘rings true’. This concept is of assistance in that it opens an avenue – alternative to the purely statistical - for exploring the psychiatric concept of normalcy: a ‘normal’ character being one with whom, when encountered in a literary work, one can achieve a sense of empathy. See the discussion in Section C (*infra*) on the novel *La Femme de Gilles*.

³¹ See Appendix C.

³² Smith (1978) is an excellent and oft cited analysis of how a group of young female friends arrive at the conclusion that one of their number is mentally ill [*i.e.* the ‘pre-diagnostic decision’] before seeking the involvement of a psychiatrist.

The power of Smith’s analysis lies in showing how a seemingly unequivocal portrayal of the onset of mental illness, can be reinterpreted as simply the ‘freezing-out’ by friends, of one of their erstwhile members.

³³ Though see Bracken & Thomas (2001) who give the following example:

A 53 year old married Sikh woman had had two admissions to hospital in the previous six years with a diagnosis of affective disorder ... She was referred urgently by her general practitioner [and] ... had pressure of speech and labile, irritable mood and was noted to be preoccupied with religion and past events in her life. Her family complained that she was overactive and spending excessive amounts of money. ... It emerged that the patient felt in conflict with her elderly mother in law, with whom the family shared the house. She believed that the elderly lady, who seemed to govern decisions about her grandchildren's forthcoming marriages, was usurping her position in the family.

Bracken & Thomas conclude: “*Framing her problems in this way rather than in terms of a medical diagnosis allowed a space in which these issues could be explored gently with the patient and her family.*”

³⁴ The term ‘misdiagnosis’ is, in relation to psychiatry, ambiguous. Amongst other meanings it may denote the categorising of a problem as a psychiatric problem when it is not; it may also mean the incorrect differential diagnosis of a psychiatric problem – *e.g.* ‘bipolar disorder’ rather than ‘schizophrenia’. The term is discussed more fully in Chapter 4.

³⁵ Mullen (1990), p.826.

that it is not uncommon that accusations which appeared delusional and which were denied by the partner and unsupported by evidence, are eventually confirmed by events. Furthermore, in the absence of studies showing a substantial possibility that a marriage can survive such a forcible psychiatric committal, a marital separation might have been a less damaging solution and should have been considered as a solution of first choice.³⁶

A.3: Was Blehein necessarily irrational?

I wish to argue that the simple holding of a belief which one cannot justify, does not, of itself, necessarily merit the belief being classed as a delusion irrespective of how resolutely one holds to the belief (religious beliefs providing a classic example of such beliefs); ‘irrationality’ enters the picture when one insists that others – whom one cannot persuade by evidence – must also accept the belief.

Blehein, in telling his wife that he believed – even that he was convinced – that she was having an affair, does not necessarily evince irrationality in that he is not seeking to insist that his wife accepts his belief rather he is challenging her to disprove his belief. However, if in discussing his beliefs with a third party such as the family GP, he insists that the GP accepts the truth of his belief without at the same time being able to justify his belief, then he is indeed irrational; the more unable to justify the belief, the more irrational. If this analysis is correct, does it follow – on the facts as stated – that Blehein was irrational?

The issue of irrationality first arises at the stage of his discussions with the family GP and it appears that here Blehein sought, not to insist that the GP unhesitatingly accept the truth of Blehein’s belief, but to defend his employment of a private detective to allay, or vindicate, his suspicions. In this he adopts an eminently rational approach to resolving his problems: namely he seeks out independent evidence of the truth or otherwise of his beliefs.³⁷

An alternative method of judging whether Blehein’s belief could be considered delusional, is by using a probabilistic analysis of the likelihood that the wife of a man such as Blehein (*i.e.* jealous and suspicious) in a marriage such as his (*i.e.* unhappy), is unfaithful. Some studies on the prevalence of marital unfaithfulness are outlined in Appendix D, and these enable a tentative conclusion to be drawn to the effect that in a marriage such as Blehein’s, the probability that his wife was unfaithful [70%] far

³⁶ Some factors – such as the attitudes and interests of GPs – that might militate against such a resolution are discussed in Chapter 4.

³⁷ Of course Blehein might simply have accepted (or, at least, pretended to accept) his wife’s denials and doubtlessly such a course of action might have caused considerably less disharmony to all parties involved, but could such a course of action be considered a more *rational* approach?

exceeds the probability that she was not [30%]. If this analysis is correct, then to believe of various possibilities, the one which is most probable, could hardly be considered as being irrational.³⁸

In conclusion, the evidence for ascribing irrationality to Blehein seems less than convincing and suggests that a psychiatric diagnosis of delusion does not necessarily imply that the subject is irrational and, *a fortiori*, manifests a degree of irrationality sufficient to warrant a coercive psychiatric intervention – a conclusion which enables *Questions 5 and 6 (supra)* to be answered provisionally³⁹ with a tentative ‘No’.

Section B: The psychiatric definition of delusion

In seeking to clarify the definition of ‘delusion’, the problem can be approached either:

- *Operationally*: by means of the psychiatric diagnostic manuals [*Subsection B.1*], or
- *Philosophically*: through philosophical writings on the psychiatric concept of delusion [*Subsection B.2*].

The Blehein case will be reviewed in the light of these discussions. [*Subsection B.3*].

Some especially problematic aspects of the definition of delusion will be identified and these will be discussed more fully in *Sections C and D*.

B.1: Operationally

The *DSM-IV-TR* (2000) defines a delusion as being:

A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everybody else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (*e.g.* it is not an article of religious faith). ...⁴⁰

It then specifies the diagnostic criteria for ‘*delusional disorder*’⁴¹ and also those for ‘*schizophrenia*’⁴² – a disorder closely related to delusional disorder.

³⁸ This is *not* to suggest that to believe in other than the most probable outcome is irrational; (see Appendix F).

³⁹ These questions will be addressed more fully in Section E.

⁴⁰ *Op. cit.*, p.821.

⁴¹ *Ibid.* p.329:

A. Nonbizarre delusions (*i.e.*, involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration.

B. Criterion A for Schizophrenia has never been met.

Note: Tactile and olfactory hallucinations may be present in Delusional Disorder if they are related to the delusional theme.

C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.

I wish to isolate three main components of the definition of delusion:

(i) “*a false belief*”:

A delusion is a belief that is firmly sustained: “... *despite what constitutes incontrovertible and obvious proof or evidence to the contrary.*”⁴³

(ii) “*based on incorrect inference*”:

This suggests that the root of delusion lies in a mistake of logic, which, in addition to the refusal to correct the mistake (the obligation to point out the mistake having been discharged) would imply irrationality.

(iii) *an unorthodox belief*:

The definition uses the following two criteria:

(a) “... *despite what almost everybody else believes ...*”

(b) “*The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g. it is not an article of religious faith)*”

I use the term ‘*unorthodox*’ to describe both of these criteria; the first being the ‘*generally unorthodox*’ criterion and the second, the ‘*culturally unorthodox*’ criterion.

B.2: Philosophically

Jaspers is considered by most commentators⁴⁴ to be the first to systematically examine the problem of delusion and he begins his discussion as follows:

Since time immemorial delusion has been taken as the basic characteristic of madness. To be mad was to be deluded and indeed what constitutes a delusion is one of the basic problems of psychopathology. To say simply that a delusion is a mistaken idea which is firmly held by the patient and which cannot be corrected gives only a superficial and incorrect answer to the problem. Definition will not dispose of the matter. Delusion is a primary phenomenon and the first thing we have to do is to get it into a proper focus.⁴⁵

D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

⁴² See Subsection C.1 (*infra*).

⁴³ *Op. cit.*, p.821.

The use of the disjunction ‘*proof or evidence*’ in this context bespeaks such an imprecise use of language as to, of itself, discredit the definition; the term ‘proof’ admits (logically) of no dissent whereas ‘evidence’ certainly does.

⁴⁴ Sedler (1995), p.252.

⁴⁵ Jaspers (1997), p.93.

In the light of Jaspers’ comments, the portrayal of madness in Greek mythology maybe of interest: Odysseus pretended madness by ploughing the sand and sowing salt; to test him, the Greeks placed his baby son in front of the plough.

He distinguishes between “*delusion-like ideas*” and “*delusions proper*”; the first “*emerges understandably from preceding affects*”⁴⁶ whilst the latter is “*psychologically irreducible ... all doubt has ceased*”.⁴⁷

Sedler (1995) summarises Jasper’s views on delusions thus:

True delusions are unmediated, direct experiences that arise in the subject as psychological givens. By contrast, other delusional phenomena always can be understood in terms of some concatenation of meaningful connections ...⁴⁸

The link between Jaspers’ perspective on delusion and the *DSM* definition of delusion is clarified by Spitzer (1990)⁴⁹ who begins his analysis by contrasting differing national psychiatric traditions⁵⁰ and traces the Anglo-American tradition back to Jaspers who was:

... the first to mention the three criteria of delusions, which are to be found in the textbooks ever since: (1) certainty, (2) incorrigibility, and (3) impossibility or falsity of content.⁵¹

These principles, according to Spitzer, found expression in the *DSM-III-R* (1987) definition of ‘delusion’ – and which, in so far as he refers to it, is essentially identical⁵² to the *DSM-IV-TR* (2000) definition (*supra*) – of which he says:

This definition poses several problems, ranging from plainly false assumptions to points of vagueness and ambiguity, as well as unjustified theoretical conjectures. As the term delusion is meant to be a purely “descriptive” term, and as this very fact is meant to guarantee the status of psychopathology and psychiatry as a science, these problems have to be addressed and discussed seriously within the psychiatric profession.⁵³

Spitzer’s criticism of the *DSM* definition of delusion is forceful and many layered; one aspect of it – the supposed ‘falsity’ of delusion – is of especial importance in relation to this dissertation argument. Spitzer writes:

The very fact that the criteria of truth or falsity are *not applicable* to various sorts of statements that the clinician nevertheless wants to subsume under the concept of delusion is frequently overlooked. The best examples are the religious delusions.

... In many cases the clinician *cannot actually disprove* the claims of the patients,

⁴⁶ *Ibid.* p.96.

⁴⁷ *Ibid.*

⁴⁸ Sedler (1995), p.254.

⁴⁹ Spitzer (1990).

⁵⁰ *Ibid.* p.378:

Contrary to German textbooks of psychiatry and psychopathology, which frankly state that there is no good definition of the term “*delusion*,” Anglo-American textbooks tend to take a less critical stance and a delusion simply is defined as a “... *firm, false, fixed idea or belief* ...”

⁵¹ *Ibid.* p.377. The attribution of these three definitional criteria to Jaspers might appear to conflict with Jaspers’ view (*supra*) on the impossibility of defining the term ‘delusion’. The point is clarified by Spitzer: “*Although Jaspers himself has pointed out that these criteria are merely first approximations ... his successors have often used them as defining criteria.*” (p.389)

⁵² Except for some minor changes, e.g. “*a false personal belief*” becomes, in *DSM-IV*, “*a false belief*”.

⁵³ *Ibid.* p.378.

but nevertheless wants to describe certain phenomenon as delusions.
... In some cases, there are delusions that actually turn out to be *true*.⁵⁴

As mentioned earlier, the suggestion that the truth of a belief does not preclude it being classified as delusional, appears incongruous. Jaspers sought to lessen the apparent incongruity by stating that the partner sometimes became unfaithful “*only as a result of the delusion*”.⁵⁵ In such cases the infidelity began subsequent to the delusion but it is clear that Jaspers was not speaking only of such cases. To him, the delusion can exist even if true.⁵⁶

Lest it be assumed that Jaspers was referring only to those situations where the ‘correctness’ of the delusion might have become apparent subsequent to the diagnosis, Fulford has argued⁵⁷ that even if the psychiatrist knew at the time of making the diagnosis, that the allegation of sexual infidelity was true (the partner, perhaps, having confided in him) this did not preclude a diagnosis of delusion provided the belief had not been adequately justified.

This aspect of delusions of infidelity – that their truth does not invalidate the diagnosis of delusion – has been commented on by Mullen and by Kingham & Gordon (2004).

Mullen writes:

Odegaard (1968) noted the frequency with which the spouses of his morbidly jealous subjects, who separated, on his advice, subsequently were found to be sexually involved with the object of their exspouses ‘delusion’. Cases where accusations which appeared delusional are emphatically denied by the partner and unsupported by any tangible evidence, but are eventually confirmed by events, are not uncommon in the experience of clinicians with an interest in jealousy.⁵⁸

A disinterested observer might be forgiven for wondering why such an observation does not prompt the conclusion that the ‘justifiability test’ as it was being applied in psychiatric practice is, if not deficient, then at least in need of radical revision. One might also wonder as to how such a test might operate in a non-psychiatric environment: are ‘normal’ people always able to justify their beliefs? As will be seen in

⁵⁴ *Ibid.* p.379 [Emphasis in original]; see also *supra*.

⁵⁵ *Op. cit.*, Spitzer then quotes an example given by Jaspers [see also *supra*]:

A delusion of jealousy, for instance, may be recognised by its typical characteristics without our needing to know whether the person has genuine ground for his jealousy or not. The delusion does not cease to be a delusion although the spouse of the patient is in fact unfaithful – sometimes only as a result of the delusion.

⁵⁶ Jaspers, (1997), p.106: “... *a delusion may be correct in content without ceasing to be a delusion, ... such correctness is accidental and uncommon – mostly it appears in delusions of jealousy.*”

⁵⁷ See Fulford (1989), p.204 (*supra*).

⁵⁸ Mullen (1990), p.826.

Section D of this chapter, they are not.⁵⁹ The appropriateness of using the ‘justifiability test’ to diagnose delusion will be discussed in Section C.

As noted in the previous paragraph, the suggestion that a particular quality or deficiency (e.g. inability to justify a belief) can serve as a criterion for diagnosing mental illness (e.g. having delusions) raises the question as to whether such quality or deficiency occurs in the mentally healthy or ‘normal’ population. But posing that question immediately raises another: what is meant by ‘normal’ in such a context? Kingham & Gordon (2004), for example, having noted that in relation to the delusion of infidelity, compulsory admission is not infrequent, continue:

It is noteworthy that individuals may suffer from morbid jealousy even when their partner is being unfaithful, provided that the evidence that they cite for unfaithfulness is incorrect and the response to such evidence on the part of the accuser is excessive or irrational. Healthy people become jealous only in response to firm evidence, are prepared to modify their beliefs and reactions as new information becomes available, and perceive a single rival.⁶⁰

The authors do not explicitly address, nor do they appear to be aware of the need to indicate, whether this latter proposition is to be construed as a definition of ‘healthy people’ – and by implication a definition of illness – or is an empirical finding based on some other definition of health.⁶¹ However, by stating that “*The prevalence of morbid jealousy is unknown, as no community survey exists.*”⁶² they implicitly acknowledge that it is not empirically grounded. Furthermore, if viewed as an empirical statement, it is inconsistent with the results of the many empirical studies which have analysed the behaviour of ‘normal’ people;⁶³ consequently, when it is viewed as a definition, it

⁵⁹ See also Appendix E where the conclusion is drawn that the belief underlying psychiatric clinical practice in relation to the diagnosis of delusion – i.e. that a mark of a ‘normal’ individual is that their beliefs (if not orthodox) can, if called upon, be justified - is itself unjustified.

⁶⁰ Kingham & Gordon (2004), p.207.

⁶¹ Foucault has commented on how psychiatry conflates the terms ‘not being like everybody else’, ‘not being normal’ and ‘being sick’. See Foucault (2004), p.95:

Très vite, ça s'est transformé en une espèce de menace psychiatrique : si tu n'es pas comme tout le monde, c'est que tu es anormal, si tu es anormal, c'est que tu es malade. Ces trois catégories : n'être pas comme tout le monde, n'être pas normal et être malade, sont tout de même très différentes et se sont trouvées assimilées les unes aux autres.

[(speaking of his homosexuality) “*Very quickly, it turned into a kind of psychiatric threat: if you are not like everyone else you are abnormal, if you are abnormal it means you are ill. These three categories, not to be like everyone, not to be normal and to be ill are still quite different and yet they have become assimilated with each other.*” C. O'Brien (trans.)]

See also Foucault (2003), p.162:

... psychiatry introduced something that until then was partly foreign to it: the norm understood as rule of conduct, ... However, by being rooted in organic and functional medicine, psychiatry is also able to exploit the norm understood in a different sense: the norm as functional regularity, as the principle of an appropriate and adjusted functioning; the “normal” as opposed to the pathological ... two usages and two realities of the norm are joined together, mutually adapted, and partially superimposed in a way that is still difficult to theorize.

⁶² Kingham & Gordon (2004), p.207.

⁶³ See *infra* and Appendix E.

would result in ‘healthy’ people being very much in the minority of the general population.

Authors such as Kingham & Gordon (2004) appear content to use the term ‘normalcy’⁶⁴ without any acknowledgement of its ambiguity – its meaning being surreptitiously changed to suit the argument being advanced. ‘Normalcy’, in such contexts, functions as a chameleon – either an exhortation to people as to how they *should* behave if they wish to be considered ‘normal’ or as a statistical term describing how people *actually* behave;⁶⁵ whilst there may be slight literary merit in such ambiguity, there is absolutely no scientific or philosophical value.⁶⁶ An even further level of confusion is apparent if one considers the use of the term “*abnormally normal*”⁶⁷ as indicating a degree of a psychiatric pathology.

[Ambiguities in the use of the term ‘normal’ will be examined in Section D.]

B.3: Blehein’s case in the light of the DSM definition of delusion

‘Delusion,’ according to the *DSM-IV-TR* (2000), involves having “*a false belief ... despite what constitutes incontrovertible and obvious proof or evidence to the contrary*”. Leaving aside for the moment the supposed ‘*falsity*’ of Blehein’s belief, where in his case, was the ‘*incontrovertible and obvious proof or evidence to the contrary*’? The difficulty in proving a negative is well known and – except in the most singular of circumstances – it seems obvious that any attempt to obtain ‘*incontrovertible and obvious proof or evidence*’ that a woman has not been unfaithful is doomed to failure, yet – according to the *DSM-IV-TR* (2000) – this was the obligation placed on Dr. Murphy before he could conclude that Blehein was delusional. But as discussed above this was not what happened: Dr. Murphy transferred – incorrectly – the onus of proof onto Blehein to prove the infidelity.

Logically, if the *DSM-IV-TR* (2000) is accorded the authority which it supposedly has in relation to clinical psychiatric practice, then Blehein was not delusional.

Blehein however did not pursue this point in his court application and it was not adverted to by the court; he conceded – although not logically obliged to – that the onus

⁶⁴ I am taking ‘[mentally] healthy’ and ‘[mentally] normal’ as synonyms and using ‘normal’ to cover both terms.

⁶⁵ See Foucault (2004) (*supra*).

⁶⁶ See, for example, Van Deemter (2010) who emphasises the dangers that can arise when the (sometimes unavoidable) imprecision of language is unacknowledged and a “*false clarity*” achieved resulting in a highly manipulable discourse.

⁶⁷ See, for example, Bolas (1987): “*A normotic person is someone who is abnormally normal. He is too stable, secure, comfortable, and socially extraverted.*” [Quoted in Genova (2002), p.8.]

of proof lay with him and his contention was that he had not been permitted to discharge this onus by virtue of the fact that the private detectives had been obstructed.

One is left with the unsettling conclusion that the authoritative compendium of diagnostic criteria – *DSM-IV-TR* (2000) – which supposedly governs the practice of clinical psychiatry, can be set at naught by the diagnosing psychiatrist with the passive acquiescence of the courts; one such as Bleheine who attempts to logically challenge the rules finds that the rules have been changed – truly a ‘*Catch-22*’.

Section C: Problematic aspects of the psychiatric concept of delusion

Abstracting from the previous discussion, I suggest that the term ‘delusion’ (as used in clinical psychiatric practice) is problematic in respect of the following five aspects:

- (i) The lack of congruence between it and the *DSM-IV-TR* (2000) definition of ‘delusion’ manifests a level of informality that may not only occasion psychiatric misdiagnosis but facilitate the use of psychiatry as a tool of political or social repression. [*Subsection C.1*]
- (ii) It places an obligation on one who espouses a belief, to justify the belief – the ‘Justifiability Criterion’. [*Subsection C.2*]
- (iii) It privileges orthodox beliefs in such a manner as to, in effect, permit unorthodoxy to be used as a diagnostic criterion for delusional belief. [*Subsection C.3*]
- (iv) It implicitly incorporates an erroneous view of the nature, and of the generative processes, of the beliefs of ‘normal’ subjects. [See *Section D* and *Appendix E*]
- (v) It uses informal judgements as to the probability of a belief being true, as a test for judging the belief to be delusional. [See *Appendix F*⁶⁸]

Before exploring these issues I wish to point out that my contention that the psychiatric use of the term ‘delusion’ is problematic, is supported by some eminent academic psychiatrists: Professor Anthony David⁶⁹, for example, writing in *Philosophy*,

⁶⁸ Where it is concluded, *inter alia*, that

- In making probability assessments, intuition (or common sense or clinical judgement) is an unreliable guide.

- Psychiatric assessments based on clinical judgement, of the improbability, or of the pervasiveness, of beliefs should be treated with considerable scepticism unless they can be shown to be grounded in reliable empirical data.

- Psychiatric assessments of the falsity of a belief based solely on the intuitive improbability of the belief, are unreliable.

⁶⁹ Anthony S. David is Professor of Cognitive Neuropsychiatry at the Institute of Psychiatry.

Psychiatry, & Psychology, notes that whilst a diagnosis of delusion has “*enormous implications*” for anyone so diagnosed,⁷⁰ the intellectual confusion surrounding the concept of delusion is such as to render it a “*shambles*”:

... despite the facade created by psychiatric textbooks, there is no acceptable (rather than accepted) definition of a delusion. Most attempted definitions begin with “*false belief*,” and this is swiftly amended to an unfounded belief to counter the circumstance where a person's belief turns out to be true. Then caveats accumulate concerning the person's culture and whether the beliefs are shared. Religious beliefs begin to cause problems here and religious delusions begin to create major conflicts. The beleaguered psychopathologist then falls back on the “*quality*” of the belief – the strength of the conviction in the face of contradictory evidence, the “*incorrigibility*,” the personal commitment, *etc.* Here, the irrationality seen in “*normal*” reasoning undermines the specificity of these characteristics for delusions ... Finally we have the add-ons ... again, sometimes equally applicable to other beliefs held by non-psychotic fanatics of one sort or another. In the end we are left with a shambles.

Why are most psychiatrists not troubled by this in their daily work?⁷¹

C.1: The informality of the criteria: openness to political abuse and misdiagnosis

Fulford (2004) adverts to the possible misuse of psychiatry:

Psychiatry is peculiar among medical disciplines in being particularly vulnerable to abusive uses for purposes of political or social control. The notorious “*delusions of reformism*”, the basis on which political dissidents were diagnosed with “*schizophrenia*” in the former Soviet Union, is but one example of our vulnerability in this respect.⁷²

This and similar mentions of psychiatric abuse seem to invariably locate it outside the modern Western psychiatric tradition and as being incompatible with this tradition.⁷³

Yet Wong Kim Eng (2006) – a textbook on psychiatry published by the University of Singapore⁷⁴ – begins its discussion of delusion with a case history which is presented as embodying an archetypical delusion:

Ah Seng, a 55-year-old divorced coffee shop assistant, was remanded at the state mental hospital a total of four times in 5 years, for distributing seditious materials. He was convinced that the government was oppressing the poor people and infiltrating an opposition party with their stooges in order to make the opposition

⁷⁰ David (1999), p.17.

⁷¹ *Ibid.* [References omitted].

⁷² Fulford (2004).

⁷³ See the discussion in the Introduction in relation to the attitude adopted by the Irish courts and especially a passage cited in *E.H. v St. Vincent's Hospital & ors* (2009):

... the statute of 2001 is a scheme of protection, ... because of course everyone, even from general knowledge, is aware of the serious misuse of the power to detain people in mental hospitals which have taken place in fairly recent times in other jurisdictions. [Emphasis added]

⁷⁴ A university in the Western tradition with links to Stanford and Uppsala Universities; it is listed 15th in the world's top ten biomedical universities.

[online], available: http://newshub.nus.edu.sg/headlines/0604/aaas_25apr06.htm [accessed 6 July 2006].

The author of the text is Associate Professor at the Institute of Mental Health, Singapore.

look foolish. He thus saw it his duty to distribute anti-government materials to force the government to step down.

... In tandem with his delusion of persecution by the government, he also harboured grandiose delusions ... As an example, he cited a politician's suicide that was caused by his prayers.

... He did not possess any other abnormal symptoms such as auditory hallucinations, passivity influence, or thought disorder. His behaviour outside of his political beliefs was otherwise normal.

Delusion being defined by Wong Kim Eng as: "... a firm, unshakeable, false belief that is out of keeping with the person's social, educational, and cultural background."⁷⁵

This definition is considerably wider than that which is common in US or European texts in that it encompasses beliefs which are not appropriate to one's social or educational background – beliefs which would not be delusions if espoused by someone with a different social or educational background. It is difficult to avoid the conclusion that one who presumes to 'rise above his station',⁷⁶ one who affects tastes and opinions not appropriate to his background, might be diagnosed as delusional; if this is correct then the vagueness implicit in the definition of 'delusional disorder' could enable it to function simply as a mechanism of social control.⁷⁷

Furthermore, the imprecision in the definition of delusion renders it extremely difficult, if not impossible, to challenge a diagnosis based on such a definition.

It should also be noted that the categorising of a delusion as a '*bizarre delusion*' is, of itself, sufficient to merit a diagnosis of schizophrenia;⁷⁸ this, in conjunction with the

⁷⁵ *Ibid.*

⁷⁶ An interesting example is provided by a psychiatric case study used by the Ludwig Binswanger which relied on a single letter written by a patient to a kitchen manager as providing sufficient grounds for a diagnostic analysis.

Lanzoni (2005), in discussing the case study, states:

According to Binswanger, the patient's letter of reproach would only have been appropriate if she had been a social superior of the kitchen manager. If a healthy person had such a complaint, she would have addressed the issue with her doctor or nurse, or those persons at the asylum with whom she was already in contact. Instead, the patient 'jumped-over' those intermediate persons who could convey the message and directly attacked the kitchen manager, with whom she had no previous relationship. (p.31)

⁷⁷ See Appendix G for a discussion of a Norwegian case which is not dissimilar to that of Ah Seng.

⁷⁸ *DSM-IV-TR* (2000), p.312: Diagnostic criteria for schizophrenia:

A. *Characteristic symptoms*: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1. delusions,
2. hallucinations,
3. disorganized speech (*e.g.*, frequent derailment or incoherence),
4. grossly disorganized or catatonic behavior,
5. negative symptoms, *i.e.*, affective flattening, alogia, or avolition.

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

[Paragraphs B to F relate to social dysfunction, duration and the exclusion of other diagnoses.]

poor reliability that has been found⁷⁹ to exist in the rating of delusions as being either ‘bizarre’ or ‘non-bizarre’, imports the vagueness inherent in the diagnosis of delusion into the diagnosis – or indeed misdiagnosis – of schizophrenia.⁸⁰

C.2: The justifiability criterion

This subsection will first discuss some formal problems concerning the justifiability criterion and show how its use – when contrasted with the falsity criterion – enhances the role of orthodoxy [C.2.1]. The link between the justifiability criterion and logical positivism is noted [C.2.2] and lastly the importance of distinguishing between the ‘justifiability criterion’ and the ‘falsity criterion’ is discussed, generally [C.2.3] and in the context of some examples [C.2.3.1 and C.2.3.2].

C.2.1: Logical difficulties concerning the justifiability criterion

According to the *DSM-IV-TR* (2000) definition of delusion, before diagnosing that a subject ‘S’ who believes ‘B’, is delusional, the psychiatrist ‘P’ is obliged to show that B is false [*The Falsity Criterion*]; being unable to discharge this obligation, P sometimes transfers the onus onto S to show that B is true [*The Justifiability Criterion*]. One consequence of this shifting of obligations is that a number of asymmetries are created which, on purely formal grounds, are difficult to justify:⁸¹

1. *Given*: P asserts that S’s belief in B and S’s inability to show that B is true, is sufficient to render S’s belief, a delusion.

Analysis: Let the proposition ‘B is false’, be called ‘C’. Hence it follows that P believes C yet P is unable to show that C is true.

Commentary: Is not P’s belief that C is true and P’s inability to show that C is true, not of exactly the same logical form as the given proposition and thus sufficient to render P’s belief in C, a delusion? And, if not, why not?

2. *Given*: Examined from a more abstract perspective, the justifiability criterion has the form: *X’s inability to justify his belief that ‘A is true’ renders it delusional.*

Question: *Does X’s inability to justify his belief that ‘not-A is true’ render X delusional or liable for a coercive psychiatric intervention?*

Analysis: A man who despites all evidence to the contrary believes his wife to be faithful might well merit the term ‘delusional’ yet it is difficult to imagine

⁷⁹ Bell (2003).

⁸⁰ See Chapter 4.

⁸¹ Leaving the orthodoxy criterion to one side for the moment.

circumstances where he would merit a psychiatric diagnosis of delusional disorder; even if such did occur, it is inconceivable that he would be subjected to a forcible psychiatric committal.

(Building on the example of the previous section) Is it conceivable that a colleague of Ah Seng could have been remanded at the state mental hospital a total of four times in 5 years, for distributing *pro*-government materials? Would his belief that his prayers were so efficacious as to be the cause of the government continuing in power, change this assessment?

Commentary: Looked at in the abstract it is difficult to see why the inability to justify 'A' might be a delusion but not so the inability to justify 'not-A'.

Possible explanations for these asymmetries might be:

(i) belief in 'A' (but not belief in 'not-A') causes disturbance for the subject's immediate family or for society generally.

Thus, when Mrs. Blehein initially approached Dr. Murphy she complained that her life was unbearable because of an alleged obsession.

In Mr. Ah Seng's case, though his family were unperturbed by his beliefs,⁸² the authorities, presumably, were not.

Such an explanation pathologises eccentric or troublesome behaviour⁸³ and leaves the door open to the very abuses for which Soviet psychiatry was condemned. It is then not the formal qualities of the belief [*e.g.* truth, consistency] that are in issue but rather the fact that the professing of the belief causes disorder or distress. In such situations the psychiatric diagnosis of delusion may – by seeking to localise the 'disorder' in the subject – act as a surrogate for beliefs which are regarded by others as deeply objectionable.

(ii) belief in 'A' (but not belief in 'not-A') is not generally accepted. The essence of this explanation is that it is the orthodoxy of a belief that provides a defence to the charge of it being a delusion; support for this explanation is found in the *DSM-IV-TR* (2000) definition of delusion.⁸⁴

⁸² Wong Kim Eng (2006): "... his friends and siblings did not think his ideas were abnormal, ... He refused to have any treatment, a decision that was strongly supported by his family."

⁸³ See Smith (1978) *supra*.

⁸⁴ *Op. cit.*, p.821: "... firmly sustained despite what almost everybody else believes ... The belief is not one ordinarily accepted by other members of the person's culture ..."

Thus though the *DSM-IV-TR* (2000) definition of delusion accords an overriding importance to orthodoxy,⁸⁵ its importance is considerably enhanced by the replacement by clinical psychiatrists, of the ‘falsity criterion’ by the ‘justifiability criterion’. The conclusion can be drawn that the clinical concept of delusion does not rest on two logically independent criteria, the ‘justifiability criterion’ and the ‘orthodoxy criterion’; rather, ‘justifiability’ must be interpreted in such a manner as to acknowledge the primacy of ‘orthodoxy’.

C.2.2: The justifiability criterion: links with logical positivism

To justify a belief one must surmount two hurdles:

- *firstly*, show that the belief is justifiable,
- *secondly*, if justifiable, give justification for the belief.

The first of these is of especial interest in that it resembles the Logical Positivist principle which holds that for a statement to be meaningful it must be verifiable.⁸⁶ The proponents of this principle believed that in it, they had captured the core of what is meant by asserting that a proposition is a ‘scientific proposition’. The verifiability principle, however, was problematic: it didn’t, for example, validate itself; furthermore it gave rise to paradoxes such as Hempel’s which asserts that the existence of a white swan was evidence for the proposition ‘*All ravens are black*’.⁸⁷

The *Oxford Companion to Philosophy* notes that, by the 1960s, Logical Positivism “*had run its course*”;⁸⁸ Popper’s concept of ‘falsifiability’ offering a more appropriate criterion for distinguishing between scientific and non-scientific discourse.⁸⁹

If the test of justifiability was found to be unworkable in such a formal setting as that of scientific discourse then, *a fortiori*, it would appear to be highly inappropriate in an informal setting such as a psychiatric interview.

C.2.3: The practical importance of the distinction between the justifiability criterion and the falsity criterion

The above discussion on the distinction between the falsity criterion and the justifiability criterion might seem abstruse and of little consequence for psychiatric practice but its importance can be recognised by noting that a diagnosis of delusion –

⁸⁵ In the sense that even if the belief has been proved by the interviewing psychiatrist to be false, it will not be considered to be delusional unless it is unorthodox; in short, a widely shared delusion is no longer a delusion.

⁸⁶ *The Stanford Encyclopedia of Philosophy* (2006): ‘Vienna Circle’.

⁸⁷ *Ibid.*: ‘Bayesian Epistemology’.

⁸⁸ Honderich (1995), p.508.

⁸⁹ Thornton (2006).

precipitating, as it possibly may, a coercive psychiatric intervention – may be grounded on the justifiability criterion whereas in identical circumstances (*e.g.* the true but unjustifiable belief in the infidelity of a wife) it cannot be grounded on the falsity criterion and consequently cannot precipitate a coercive psychiatric intervention. Two examples – one from the world of politics and the second from the world of literature and embodying, what was earlier termed , ‘*Literary Truth*’ – may help to highlight the importance of the distinction. In neither example is the subject capable of satisfying the justifiability criterion and in neither is the psychiatrist capable of satisfying the falsity criterion; thus under the *DSM* criteria neither are delusional yet both might be found to be delusional by a clinical psychiatrist.

C.2.3.1: The ‘Martha Mitchell Effect’

Bell⁹⁰ describes the effect as follows:

The ‘Martha Mitchell effect’ referred to the tendency of mental health practitioners not to believe the experience of the wife of the American attorney general, whose persistent reports of corruption in the Nixon White House were initially dismissed as evidence of delusional thinking, until later proved correct by the Watergate investigation. Such examples demonstrate that delusional pathology can often lie in the failure or inability to verify whether the events have actually taken place, no matter how improbable intuitively they might appear to the busy clinician.

C.2.3.2: La Femme de Gilles

The following excerpts are from the novel *La Femme de Gilles* by Madeleine Bourdouxhe, and describe how Elisa (who is married to Gilles) suddenly becomes aware of a sexual tension between Gilles and Elisa’s younger sister, Victorine:

Victorine, in gloves and hat, was all ready to go, leaning on the table with both hands. He was very close to her. Turning her back on the room, Elisa stood by the wardrobe and rummaged in her handbag. ... Precisely at that moment Elisa knew that behind her back there was another world, a world that was complicated, threatening, unknown. She felt it to be so and she was certain she was not mistaken; she was also certain that it was absolutely essential not to turn round suddenly and confront it. Disturbed by this mysterious insight, which seemed suddenly to have seized her by the throat,⁹¹ she waited a moment before slowly turning, at first only halfway, looking straight in front of her with faraway eyes, then three-quarters, then at last full face. She looked at them both. They seemed not to have moved: they were in exactly the same position they had been in a few minutes earlier, before she had had her insight.⁹²

⁹⁰ Bell (2003).

⁹¹ This description would appear to fit Jaspers’ description of “*delusions proper*” as being “*psychologically irreducible ... all doubt has ceased*”. Jaspers (1997), p.96.

⁹² Bourdouxhe (1992), p.13-14.

... She thought: '*For several weeks something has been going on between Gilles and Victorine. It may even be too late to prevent the worst.*'⁹³

Elisa suspects, rightly, that her husband is beginning an affair with Victorine. If asked to justify her belief, she would be unable; she would be forced into a silence or, at best, a mumbling inarticulacy about the meaning of glances: furtive and sexual. Is Elisa suffering from delusion? I suggest not, I believe that her character has a '*literary truth*': that a reader of the novel can empathise with Elisa and can recollect, or imagine, similar situations where the attraction between people will have been obvious to those perceptive enough to notice.⁹⁴ But this is just a surmise, it is beyond proof; but could an assertion that Elisa is delusional rest on firmer ground? True it may accord with the definition of delusion as utilised in clinical psychiatry, but is this definition valid or, more accurately, is 'delusional disorder' a valid disorder?

The suggestion that certain psychiatric disorders have no validity – that although well defined, they reflect no pathology – will be discussed in Chapter 4 in relation to misdiagnosis. As will be seen when discussing normalcy [Section D (*infra*)], (statistically) normal behaviour deviates considerably from the ideal imagined by Kingham & Gordon (2004) where normal people are dispassionate weighers of evidence who "*become jealous only in response to firm evidence*". It may well be that trains of thought such as Elisa's – far from being pathological – may be statistically normal. Are these categories – the pathological and the statistically normal – necessarily mutually exclusive? If so, Elisa's beliefs (which she would be unable to justify) could not be delusional.

C.3: Orthodoxy as a criterion

Assume for a moment that the orthodoxy criterion was the sole criterion used in defining a delusion: *i.e.* that the unorthodoxy of a belief was sufficient to render it a delusion; such a definition would place psychiatry in the same position as was the Spanish Inquisition, but now enforcing a secular, rather than a religious, orthodoxy. Such a development would clearly be incompatible with, and antagonistic to, the role accorded to psychiatry in modern liberal democracies. But if orthodoxy (considered as a sole criterion for delusion) strikes at the heart of the Western liberal tradition, why should it be any less unacceptable when allied with other criteria?

⁹³ *Ibid.* p.17.

⁹⁴ Compare Elisa's perceptions with the comments of an art critic [Campbell (2005)]: "*The figures are arranged in stances that let you know – as they do when you come into a room where a row has been going on – that something is wrong.*"

Orthodoxy, as I have used the term, is the claim that because a belief is widely shared it has – by virtue of that very fact alone – a special claim to be considered true; thus when the truth of an orthodox belief is put in question the onus is placed on the one who disagrees with the belief, to prove his position. Alternatively, it is the claim that if neither a statement nor its negation is amenable to proof, the orthodox belief should be accepted. Spitzer (1990) appears to go further⁹⁵ and to actually equate truth with orthodox belief:

The phrases “*what almost everyone else believes*” and “*in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary*” both merely clarify what it means for a notion to be false either by reference to the failure to meet some statistical norm ...

Some philosophers in that they seek the resolution of philosophical difficulties through an analysis of ordinary language, effect a privileging of orthodoxy and ‘normalcy’; in doing so they bend, distort and lessen the richness of the world⁹⁶ until it fits the ready-made perceptions of the man on the Clapham Omnibus. David Papineau,⁹⁷ writing on this tendency within philosophy, states:

Given this, it is inevitable that the best philosophical theories will be those that match everyday common sense as far as possible. Or so at least my colleagues argue.

I don’t buy this at all. It can’t possibly be a good idea to assess philosophical theories by the extent to which they preserve everyday intuitions. The trouble is that everyday intuitions are often nothing more than bad old theories in disguise. Any amount of nonsense was once part of common sense, and much nonsense no doubt still is. It was once absolutely obvious that the heavens revolve around the earth each day, that the heart is the seat of the soul, that without religion there can be no morality, ...⁹⁸

When such strategies are restricted to philosophy, they can, perhaps, be dismissed as academic theorising⁹⁹ but when incorporated into psychiatry they become the mechanism whereby orthodoxy can be enforced; it should be remembered that the Soviet dissidents who were subjected to psychiatric abuse, were first of all *dissidents* *i.e.* holders of unorthodox beliefs.

⁹⁵ Blankenburg (2001) adopts an even more extreme position. [See Appendix F]

⁹⁶ As described by the poet Louis MacNeice:

*World is crazier and more of it than we think,
Incorrigibly plural. I peel and portion
A tangerine and spit the pips and feel
The drunkenness of things being various.*

[MacNeice (2005), p.18].

⁹⁷ David Papineau is Professor of Philosophy of Science at King's College, London.

⁹⁸ Papineau (2006). See Appendix F for a fuller discussion of these issues.

⁹⁹ Though see Section E (*infra*) where the philosophical analysis of two sets of beliefs – *viz.* unjustifiable belief in sexual infidelity and unjustifiable belief in childhood sexual abuse – reach radically different conclusions and suggest a case of special pleading if not of double standards.

Section D: Problematic aspects of the psychiatric concept of normalcy

Bertrand Russell once opined¹⁰⁰ that most of the beliefs of most individuals were – if not contrary to the available evidence – incapable of being justified. Perhaps he was being overly polemic but nonetheless implicit in his argument is the recognition that the situation could hardly be otherwise: personal beliefs are so complex and draw on so many sources for their sustenance, that they are essentially incapable of rigorous formulation and analysis. Russell was deeply schooled in logic and, working as he did on the foundations of mathematics, was fully aware of its limitations: fully aware that man does not – indeed cannot – function as a type of proof machine scooping up premises, testing them, stringing them into syllogisms, bagging the conclusion and then heading ever onwards; ready at the slightest murmur of dissent to display all the steps which enabled him to reach his present position.¹⁰¹ Such a procedure may be possible when analysing the foundations of mathematics but it of little assistance in navigating the ever-moving flux of life which daily lies before us.

Is Russell correct in his belief that irrationality is widespread? Do normal people not only espouse beliefs which they cannot justify, but ignore evidence which undermines these beliefs? The answer to these questions are of importance in assessing the credence that should be accorded to psychiatric determinations of pathology.

‘Pathological’ and ‘normal’ are complementary concepts: one does not envisage the normal being pathological nor the pathological being normal; yet ‘normal’ is an ambiguous concept. It can mean one who is statistically normal – *i.e.* within some interval centred on the mean or median; or it can refer to an ideal – *e.g.* to one who is particularly well adapted to pursue his life’s task. The particular meaning chosen by psychiatry can, to a large extent, determine the role that psychiatry plays in society; Maslow, for example, who believed that psychiatry should choose the second meaning – and accordingly spoke of the “*self actualizing person*”,¹⁰² – argued that psychiatry

¹⁰⁰ Russell (1952): “... *nine-tenths of the beliefs of nine-tenths of mankind are totally irrational.*”

¹⁰¹ Descartes’ philosophy appears to countenance such a view of the individual: one who builds ever outward from the secure foundations of the *Cogito* and in doing so appropriates the world. Wittgenstein’s perspective is different: we cannot but start *in medias res*. [See, for example, Williams (1999)].

¹⁰² Maslow (1971), pp.40-51.

Similarly, Carl Rogers spoke of the ‘*fully functioning person*’ and Hayakawa synthesised Rogers’ and Maslow’s concepts into the ‘*genuinely sane individual*’. [see Hayakawa (1956), p.171.]

eschewed this role in favour of the “*assumption that the individual is always wrong and proceeds to do its best to adjust him to the environment*”.¹⁰³

More modern commentators confirm that psychiatrists continue to identify ‘normalcy’ with ‘social conformity’: Professors Wiggins and Schwartz¹⁰⁴ writing from their perspective as editors of the journal *Philosophy, Psychiatry, & Psychology*, state:

... American psychiatrists rarely study mentally healthy people. ... Psychiatry lacks a conception of healthy mental life; *i.e.*, it lacks an understanding of psychological normalcy. As a result, most aspects of patients' lives are perceived in pathological terms. ... By default, then, mental health comes to mean social conformity. For children this means conformity to the expectations of parents, ... Mental health in adults means conformity to society's expectations. There exist large numbers of mental health experts ... who are prepared to misdiagnose nonconformity as a mental disorder.¹⁰⁵

But this use of ‘normalcy’ is problematic because – as will be shown – the psychiatric conception of (statistical) normalcy is not based on empirical investigation but on intuition and this is an extremely unreliable guide when making probabilistic assessments.¹⁰⁶

This raises a further problem: to psychiatrists, the pathological and the normal are mutually exclusive and exhaustive categories;¹⁰⁷ if, however, it transpires that the psychiatric ideal of the normal is not statistically normal then this *necessarily*¹⁰⁸ subverts the psychiatric conception of the pathological. In other words, if it is the case that the pathological (as defined by psychiatry) and the normal (as defined statistically) are not distinct, mutually exclusive, classes then this undermines the validity of the psychiatric diagnostic categories.

For example, Kingham & Gordon (2004) in their characterisation of “*healthy people*”¹⁰⁹ defend the onus placed on the one who professes a belief, to justify that belief or run the risk of it being classed as delusional. If it can be shown that (statistically) normal behaviour in relation to the holding of beliefs, differs markedly from the normal as

¹⁰³ Hoffman (1989), p.43. Strictly speaking, Maslow was speaking of psychoanalysis rather than psychiatry but this is attributable to the, then current, nomenclature.

Hayakawa (1956) notes that: “*The MOST impressive fact as described by both Rogers and Maslow is that these sane people are not in the ordinary sense of the term well adjusted.*” (p.172.) [Emphasis in original].

¹⁰⁴ Dr. Schwartz is professor of psychiatry at Case Western Reserve University. Dr. Wiggins is professor of philosophy at the University of Louisville. Both are founders of the Association for the Advancement of Philosophy and Psychiatry.

¹⁰⁵ Wiggins & Schwartz (1999).

¹⁰⁶ See Appendix F.

¹⁰⁷ This is not to deny that there may be borderline cases but the existence of such cases does not invalidate the point at issue.

¹⁰⁸ ‘*Necessarily*’ *i.e.* if the pathological and the normal are to remain mutually exclusive and exhaustive categories.

¹⁰⁹ *Op. cit.*, p.207 and *supra*: “*Healthy people become jealous only in response to firm evidence, are prepared to modify their beliefs and reactions as new information becomes available.*”

idealised in clinical psychiatry, then the use of the ‘justification criterion’ in relation to beliefs is seriously challenged and the coherence of the concept of delusion, as used in clinical psychiatry, grievously undermined.

The issues at the core of this discussion are twofold: the first concerns the accuracy of the psychiatric conception of the normal and the second, the accuracy of the psychiatric conception of the pathological.

I shall take Kingham & Gordon’s (2004) statement (*supra*) as emblematic of the psychiatric perception of how (statistically) normal people form and adjust their beliefs (it, or some equivalent formulation, underlies the Justifiability Criterion¹¹⁰) and show that they are erroneous [*Subsection D.1*]. I shall then examine some behaviours and beliefs which psychiatrists take as indicative of pathology (*e.g.* the hearing of voices) and show that they are prevalent amongst subjects who are considered (psychiatrically) normal [*Subsection D.2*]. In the light of these discussions, the question whether the (psychiatrically) pathological and the (statistically) normal are distinct, mutually exclusive, categories is reviewed in *Subsection D.3*.

D.1: The accuracy of the psychiatric conception of the normal

Two aspects are of especial interest:

- the prevalence of unjustifiable beliefs amongst ‘normal’ subjects; [*D.1.1*]
- the unwillingness of ‘normal’ subjects to modify their beliefs in the face of conflicting evidence. [*D.1.2*]

D.1.1: The prevalence of unjustifiable beliefs amongst ‘normals’

Unusual, unjustifiable, and sometimes bizarre beliefs are widespread in Western societies; for example, a Gallup (2005) survey found that:

... just about three in four Americans hold some paranormal belief in at least one of the following: extra sensory perception (ESP), haunted houses, ghosts, mental telepathy, clairvoyance, astrology, communicating with the dead, witches, reincarnation, and channeling.

¹¹⁰ The disparity between the presumptions underlying the justifiability criterion and the belief patterns of normal subjects finds an interesting expression in ‘*The Edge Annual Question of 2005*’ which asked 120 scientists and philosophers of such eminence as Richard Dawkins and Daniel Dennett, “*What Do You Believe Is True Even Though You Cannot Prove It?*”.

One contributor’s response is of special interest in the present context – Randolph Nesse, who is a professor of psychiatry at the University of Michigan, said:

I can’t prove it, but I am pretty sure that people gain a selective advantage from believing in things they can’t prove. I am dead serious about this. People who are sometimes consumed by false beliefs do better than those who insist on evidence before they believe and act. People who are sometimes swept away by emotions do better in life than those who calculate every move. ...

Further examples are discussed in *Appendix E* which also gives examples showing that the holding of such beliefs also extends to academics and the professions.

On the basis of such studies it is possible to argue that one who *refused* to believe in phenomena such as the paranormal, was not (statistically) normal.¹¹¹

However, not only do the actual beliefs espoused by (statistically) normal subjects not accord with the psychiatric model of the normal individual, but (statistically) normal subjects also appear to display an unwillingness of to modify these beliefs when faced with disconfirmatory evidence.

D.1.2: The unwillingness of ‘normals’ to modify their beliefs

Francis Bacon, writing in 1620, argued that:

The human understanding when it has once adopted an opinion (either as being the received opinion or as being agreeable to itself) draws all things else to support and agree with it. And though there be a greater number and weight of instances to be found on the other side, yet these it either neglects and despises, or else by some distinction sets aside and rejects, in order that by this great and pernicious predetermination the authority of its former conclusions may remain inviolate.¹¹²

This is so curiously at odds with Kingham & Gordon’s (2004) description (*supra*) of how ‘healthy’ people modify their beliefs in relation to new evidence that one might be forgiven for wondering whether the Age of Enlightenment could possibly have wrought such a monumental change in human nature over the intervening centuries.

Unfortunately, the evidence suggests that it is Bacon’s perception that best describes the behaviour of (statistically) normal subjects in the modern world. A recent study provides an example of such evidence; it sought to determine how normal subjects, having heard the same information, can arrive at diametrically opposed conclusions.¹¹³

This study exemplifies the phenomenon of ‘*Confirmation Bias*’,¹¹⁴ which refers to the “*ubiquitous*”¹¹⁵ tendency of ‘normal’ subjects to seek confirmatory evidence for an

¹¹¹ Hence ‘unorthodox’ (in the sense mentioned earlier) and accordingly ‘delusional’ unless he could justify his disbelief.

¹¹² Bacon (1620).

¹¹³ Emory University (2006) took a sample of committed Democrats and Republicans and monitored the subjects’ responses to political campaign material during the 2004 presidential election. The study author concluded that: “*Essentially, it appears as if partisans twirl the cognitive kaleidoscope until they get the conclusions they want, ...*”

¹¹⁴ It was first investigated by Wason as a possible explanation for the systematic errors made in relation to the ‘*Wason Card Selection Task*’. [Barash (2003)]

¹¹⁵ Nickerson (1998) who states:

If one were to attempt to identify a single problematic aspect of human reasoning that deserves attention above all others, the confirmation bias would have to be among the candidates for consideration. (p.175).

hypothesis, rather than disconfirmatory evidence as required by the scientific method; much medical misdiagnosis is traceable to this bias.¹¹⁶

Lest it be thought that within academia, the confirmation bias would not occur, I wish to mention a particularly revealing study¹¹⁷ which involved the recruitment of a group of subjects (who all had doctorates in natural science) from the staff of two major research universities ostensibly to review, and perform, the experiments in a mock ‘textbook’ on 3-D geometry. The participants were recruited as ‘consultants’ and paid a standard fee; a bonus fee had been promised to all who successfully completed the exercises as set out in the ‘textbook’.

The ‘textbook’ gave an incorrect formula for the volume of a sphere and, as a first exercise, the participants were asked to calculate the volume experimentally (a screening process had eliminated volunteers who knew the correct formula), to calculate the volume using the formula and then to compare the results. The aim of the study was to determine the strategies¹¹⁸ used by these scientists to reconcile their results; it concluded that:

Our results on belief-dependence of observations suggest that even when one deals with simple tasks such as measuring length with a ruler, and even when these tasks are undertaken by a select group of highly trained individuals, many people tend to resolve a conflict between firm beliefs and sense data by adjusting the data.

... The tendency to cling to strongly held beliefs in face of overwhelming evidence against them is a recurring feature of human affairs, ...

... Most participants in this study were unable to relinquish unreasonable beliefs, even when these beliefs have just suffered seemingly decisive refutations.¹¹⁹

D.2: The accuracy of the psychiatric conception of the pathological

The above discussion did not distinguish between unjustified beliefs considered generally, and those – such as delusions, paranoia and ‘hearing voices’ – which have an especial relevance to psychiatry. If, however, beliefs which psychiatrists would generally hold to be pathological – and, perhaps, sufficient to justify a coercive psychiatric intervention – are found to be prevalent amongst the (statistically) ‘normal’ population then this reflects directly on the validity of psychiatric diagnostic criteria.

¹¹⁶ Nickerson (1998), pp.192-3. [See also Chapter 5 *infra*]

¹¹⁷ Nissani (1992).

¹¹⁸ *Op. cit.*:

... one mechanism of resolving the apparent conflict involved partial adjustments of measurements in order to bring them in closer conformity with expectations. A second common response involved the invocation of experimental error ... only one scientist rejected the validity of the formula on the verbal level.

¹¹⁹ *Op. cit.*, [References omitted]

This subsection examines the prevalence of such phenomena in the (statistically) ‘normal’ population: ‘delusions’ [D.2.1]; ‘paranoia’ [D.2.2]; and ‘hearing voices’ [D.2.3].

D.2.1: Prevalence of delusions amongst normal subjects

Richard Bentall¹²⁰ has analysed¹²¹ the only study of which he is aware, that examined the prevalence of delusion in the general population. This was a 1996 French study which found that (of those with no history of psychiatric disorder):

- 69.3% reported that others were not who they seemed to be;
- 46.9% had experienced telepathic communication;
- 42.2% believed that seemingly innocuous events had a double meaning;
- 25.5% believed that they were being persecuted in some way;
- 23.4% believed that occult forces were at work.¹²²

D.2.2: Prevalence of paranoia amongst normal subjects

Freeman (2005) examined the prevalence of paranoid thought amongst ‘normal’ UK university students; it noted that no comparable research findings had hitherto been published.

Amongst its findings were that:

(i) 96% had the occasional thought that “*I can detect coded messages about me in the press/TV/radio*”; 3% had this thought weekly.¹²³

(ii) 81% had the occasional thought that “*My actions and thoughts might be controlled by others*”; 8% had this thought weekly.¹²⁴

(iii) Paranoid thoughts occurred regularly in approximately a third of the group ... it is possible that paranoid ideation is almost as common as symptoms of anxiety and depression.¹²⁵

(iv) Our survey clearly indicates that suspicious thoughts are a weekly occurrence for many people: ... 10–30% had persecutory thoughts, with thoughts of mild threat (e.g. ‘*People deliberately try to irritate me*’) being more common than severe threat (e.g. ‘*Someone has it in for me*’).¹²⁶

(v) Interestingly, the ideation captured in this survey did not seem to be restricted to passing thoughts that were dismissed almost in the same instant that they occurred. Approximately 10–20% of the survey respondents held paranoid ideation with strong conviction and significant distress.¹²⁷

¹²⁰ Professor of Clinical Psychology at the University of Manchester.

¹²¹ Bentall (2003).

¹²² *Op. cit.*, p.101.

¹²³ *Op. cit.*, p.429; Table 1.

¹²⁴ *Ibid.*

¹²⁵ *Op. cit.*, p.427.

¹²⁶ *Op. cit.*, p.433.

¹²⁷ *Ibid.*

Interviewed subsequently by the BBC, the lead author Dr. Freeman said: "*We were astonished at how common paranoia and suspicion are amongst the population*". Dr. Freeman said that previously, paranoid thinking had been assumed to occur only in people with severe mental illness.¹²⁸

Perhaps even more than Dr. Freeman's actual findings, his expression of surprise at his results and the fact that his research team was drawn from the London Institute of Psychiatry lends eloquent testimony to Wiggins & Schwartz's (1999) view (*supra*) that psychiatry lacks an understanding of psychological normalcy.

D.2.3: Prevalence of 'hearing voices' amongst normal subjects

British Psychological Society (2000) reported that "*Perhaps as many as one in ten of the general public hear voices regularly.*"¹²⁹ It details the experiences of a Dutch psychiatrist, Professor Romme, who – rather than following the established practice of urging subjects to suppress any internal voices they might 'hear' – suggested that subjects should learn to accept their voices as real and meaningful and attempt a dialogue. In the furtherance of his work he became aware that the experience of 'hearing voices' was considerably more prevalent than he had expected:

... we met a considerable number of men and women who heard voices but had never been psychiatric patients nor considered themselves mentally ill. Nor, for that matter, were they seen as mentally ill by their family and friends. When we first met these people ... we were quite astounded because, like most psychiatrists and indeed most lay people, we were used to regarding people who hear voices as mentally distressed. We were forced to change our ideas when we were confronted with well-balanced, healthy people who simply happened to hear voices: voices which were not heard by those around them, and which they experienced as coming from outside.

... There are people who have developed a very positive relationship with the experience of hearing voices, and have managed without any psychiatric treatment or support.¹³⁰

D.3: The relationship between the (psychiatrically) pathological and the (statistically) normal

To establish that a deep disjuncture exists between the actuality, and the psychiatric perception, of the nature (and the generative process) of the beliefs of normal subjects, it would first be necessary to:

¹²⁸ BBC (2006). '*Paranoia: widespread problem*'. 3 July. [online], available: <http://news.bbc.co.uk/2/hi/health/5126208.stm> [accessed 1 August 2006].

¹²⁹ British Psychological Society (2000), p.12.

¹³⁰ *Op. cit.*, p.13, citing Romme, M. & Escher, S. (1993). *Accepting voices*. London: MIND. p.59 and p.7.

- (i) restrict the types of beliefs to those which – if held by a subject – would be commonly regarded by psychiatrists as indicating the presence of psychiatric illness (call these ‘*beliefs symptomatic of psychiatric illness*’)
- (ii) determine the actual prevalence of such beliefs amongst normal subjects.
- (iii) determine the estimates made by psychiatrists of the prevalence of such beliefs amongst normal subjects.

It would then be necessary to exhibit a gross disparity between the estimates found in steps (ii) and (iii). Whilst estimates for (ii) have been given (*supra*) for some delusions (*i.e.* ‘paranoia’ and ‘hearing voices’), estimates for (iii) are not readily available.

However, the problem can be tackled indirectly: Professor Romme was “*quite astounded*” and Dr. Freeman was “*astonished*” at the prevalence of ‘beliefs symptomatic of psychiatric illness’ in the normal population; their astoundedness and astonishment was expressed, however, not simply on their own behalf but on behalf of their profession:

- Dr. Freeman said that in the past paranoid thinking had been assumed to occur only in people with severe mental illness;
- Professor Romme that “*like most psychiatrists ... we were used to regarding people who hear voices as mentally distressed*”¹³¹.

Unless these eminent psychiatrists were utterly mistaken about the beliefs of their professional colleagues, it is difficult to resist the conclusion that the extent of paranoia and ‘hearing voices’ in the general population is unknown to most practising psychiatrists.¹³² Furthermore, if there is such a dearth of research on what normal subjects *actually* believe then it might reasonably be assumed that knowledge of the beliefs of practicing psychiatrists as to the beliefs of normal subjects is even more obscure. If one is entitled to conclude that the knowledge displayed by psychiatrists of the beliefs and behaviour of normal subjects is poor, and if normalcy and pathology are mutually exclusive, exhaustive, categories, then this leads ineluctably to the conclusion that psychiatric determinations of pathology are less than wholly reliable. Ironically, it also implies that some of the beliefs of psychiatrists as to what constitutes normalcy and pathology are not capable of justification.

¹³¹ *Supra*.

¹³² Romme’s comment (“... *well-balanced, healthy people who simply happened to hear voices.*”) and Freeman’s choice of “*normal university students*” as his subject group, should be sufficient to dispel the objection that, like physical illness, much psychiatrically pathological behaviour might not come to the attention of psychiatrists.

Section E: The justifiability criterion: a philosophical ‘double standard’?

The clinical psychiatric concept of delusion has been criticised in earlier sections principally because of the reliance that it places on the justifiability criterion – a reliance which has received the *imprimatur* of philosophers of psychiatry of such eminence as Jaspers and Fulford (*supra*); the voices raised in objections, though eminent, have been few and isolated [*e.g.* David (1999) *supra*].

It is of interest to see whether the justification criterion is equally acceptable to philosophers when applied in other contexts where the reliability of a belief is in question. If it is not, then the question may be posed as to whether philosophers are applying a ‘double standard’ and whether the results of supposed impartial philosophical analyses are being decided *ab initio* on the basis of preserving a supposed commonsensical *status quo*.¹³³

Beliefs by adults that they had been sexually abused as children are analogous to beliefs by husbands in the sexual infidelity of their spouses, in that – in circumstances where the beliefs are not capable of justification – their reliability is open to question. Based on the earlier discussion of delusions of infidelity, one might expect that the unshakeable belief that one had been sexually abused as a child whilst being unable to offer independent justification for the belief, could also be capable of being classified as a ‘delusion’. However an issue of the journal *Philosophy, Psychiatry, & Psychology*, focused on the reliability that should be accorded to allegation of sexual abuse. Some philosophers¹³⁴ who contributed to the issue – not only did not advert to the possibility of delusion – but argued that the beliefs should be accepted as being true;¹³⁵ the arguments centred on the theory of ‘reliabilism’ and are discussed in Subsection E.1. Some problematic aspects of the philosophical analysis of reliabilism as applied to beliefs in sexual abuse, are discussed in Subsection E.2. In the light of the theory of reliabilism, delusions of infidelity are revisited in Subsection E.3 and the philosophical stance adopted towards the unjustified belief of a daughter that she had been sexually

¹³³ See Papineau (2006) *supra*.

¹³⁴ Freedman (2007a); Nissim-Sabat (2007); Potter (2007); Lieberman (2007) and Freedman (2007b).

¹³⁵ Though Nissim-Sabat (2007) argues that Freedman’s (2007a) example does not require the jettisoning of the justification criterion:

In the case of the victims of sexual abuse, we would then say that they do not know what they claim to know because they, as free, agentic persons, have chosen for a variety of reasons not to know, they have denied access to themselves. [p.17.]

abused by her father, is contrasted with that adopted towards the unjustified belief of a husband that his wife had been unfaithful.

Conclusions are drawn in *Subsection E.4*.

E.1: ‘Reliabilism’ in the context of unjustifiable beliefs

Problematic aspects of the traditional philosophical view that “... *when we claim to know or to believe we claim to have reasons that justify us.*”¹³⁶ were highlighted by Gettier (1963).¹³⁷ The theory of ‘*reliabilism*’, which was developed in response to these difficulties, held that the need to justify a belief could be dispensed with in circumstances where the belief in question flowed from what had hitherto been found to be, a reliable method of generating beliefs.

An example discussed by Brandom (1988) was taken by Freedman (2007a) *et al* as providing a focus for the discussion: Brandom had taken the case of industrial chicken-sexers¹³⁸ who, when questioned, were unable to explain how they achieved their success. He described this phenomenon as ‘*super blindsightedness*’¹³⁹ and argued that it was a rare phenomenon.

Freedman’s (2007a) argument – which sought to apply Gettier (1963) and Brandom (1988) to the beliefs of ‘survivors’ of sexual abuse – is sketched in *E.1.1* and some responses to it are discussed in *E.1.2*.

E.1.1: Freedman’s (2007a) argument

Freedman (2007a) having noted the consequences flowing from Gettier (1963) namely that “... *justified true belief is insufficient for knowledge*”,¹⁴⁰ discussed the rise of externalist epistemologies which offered ‘*reliability*’ as a possible replacement for the

¹³⁶ Lieberman (2007), p.23.

¹³⁷ Gettier (1963). Prior to Gettier’s paper it had been assumed that a set of necessary and sufficient conditions for stating that ‘*S knows that P*’ were:

- (i) P is true,
- (ii) S believes that P, and
- (iii) S is justified in believing that P.

Gettier argued that the proposition ‘S knows P’ implies the proposition ‘S knows *PorQ*’; then using particular examples, he considers a proposition R (implied by *PorQ*) which is true, believed in by S, who is justified in his belief but of whom one could not say that he ‘knows that R’.

The strength of Gettier’s argument is diminished somewhat in the realisation that it relies on the acceptance of ‘material implication’ as an adequate reflection of logical implication.

Gettier’s argument has no relevance to a discussion of whether a subject can be said to ‘know’ that she has been sexually abused.

¹³⁸ Workers who were able to quickly and reliably segregate male from female chickens.

¹³⁹ Polanyi’s (1962) concept of ‘*tacit knowledge*’ describes a similar phenomenon.

¹⁴⁰ Freedman (2007a), p.3; see also Gettier (1963):

... in that sense of ‘justified’ in which S’s being justified in believing P is a necessary condition of S’s knowing that P, it is possible for a person to be justified in believing a proposition that is in fact false. (p.121)

justification criterion in defining what it means ‘to know’. On reliabilist accounts of knowledge, she argues, “*reliable methods of belief acquisition are a reason to think that our beliefs are true*”.¹⁴¹

Freedman (2007a) then seeks to apply these theories to survivors of sexual abuse arguing that they also manifest a “*super blindsightedness*” which is reliable and that this shows that the phenomenon of ‘super blindsightedness’ is much less rare than was suggested by Brandom.

Posing the problem in the abstract, she first discusses the circumstances when a subject ‘S’ is entitled to say that she ‘knows’ that proposition ‘p’ is true. If S can justify her belief then clearly¹⁴² she can state that she ‘knows’ p; thus the ability to justify is a sufficient condition for knowing but is it a necessary condition? Freedman (2007a) thinks not:

But there are other cases where we want to say that S knows that p, even though S cannot defend her belief that p, ... That S can know that p, even though S cannot offer a reasoned defense of p is a consequence of the key insight of epistemic externalism. On this view, what counts is that a subject acquires her beliefs using reliable methods, say ones that tend to produce true beliefs, and not that she has a cognitive grasp of these methods.¹⁴³

Freedman (2007a) focuses her discussion on the sexual abuse survivor who has no direct memory (or independent evidence) of her abuse but nonetheless is unshakably convinced that the abuse occurred; to Freedman, this example shows “... *that it is common for an individual to know that p even if she cannot give reasons, or provide evidence, for why she believes that p*”.¹⁴⁴

Freedman’s (2007a) argument centres on the fact that the sexual abuse survivor has a ‘reliable’ method of knowing that she has been abused. Having cited statistics on the extent of sexual abuse, she continues:

The facts on sexual violence against women, as evidenced by these statistics, go to show that the beliefs formed in the aftermath of sexual violence are indeed reliably formed, that is likely to be true.¹⁴⁵

Freedman (2007a) draws a conclusion from her discussion, which transcends the immediate context of sexual abuse survivors, she states:

In fact, as it turns out, there are whole populations of individuals who, with respect to some of their core beliefs about the world, know even though they cannot defend those beliefs.¹⁴⁶

¹⁴¹ *Ibid*, p.4.

¹⁴² *Contra* see Gettier (1963) *supra*.

¹⁴³ *Ibid*, p.1.

¹⁴⁴ *Ibid*, p.2.

¹⁴⁵ *Ibid*, p.6.

¹⁴⁶ *Ibid*, p.9; Elisa’s beliefs (*supra*) provide an example.

E.1.2: Responses to Freedman (2007a)

In reply, Lieberman (2007) and Potter (2007) broadly agree with Freedman (2007a) whereas Nissim-Sabat (2007) disagrees.¹⁴⁷

Freedman (2007b) is a riposte.

Lieberman (2007)

Lieberman (2007) argues in support of an even broader conclusion than Freedman (2007a):

In fact, I think that if we canvas our lives, we will find that much of what we claim to know or believe is not based on our having reasons in mind (or on reliability). ... As unsatisfying as this point may be, the conclusion that it can make sense to say that we know or believe, without knowing how or why, seems a more accurate representation of what our lives are like than a purely mechanistic, biologic view that ignores or devalues such phenomena as super blindsightedness (unconscious life) altogether.¹⁴⁸

Potter (2007)

Potter (2007), taking examples from clinical psychiatry, accepts reliabilism in the case of the clinical psychiatrist but not in the case of the psychiatric patient.

She gives the example of a patient claiming to be depressed and suicidal; the attending psychiatrist assesses the patient as malingering,

... without being able to give reasons. He has a gut feeling, but is unable to articulate the source of the intuition. ... The reliability, in this case, most likely rests on the attending's longterm observation of patients, sensory data that he is taking in on a subconscious level, memory of other patients who say they are depressed or suicidal, and so on.¹⁴⁹

The patient, however, is subject to a stricter standard:

When a patient cannot give reasons for his beliefs, the status of those beliefs is called into question. This is why it is important to appreciate the status of reliabilism as a theory of knowledge: Without reasons, all we have to rest upon is reliable belief formation — but without knowing how a belief was formed, the clinician is not in a position to decide whether or not the process was reliable.¹⁵⁰

Potter gently chides Freedman on her apparently one-sided understanding of reliabilism:

Freedman argues that, given the epidemic proportions of violence against women, it is reasonable to view a patient who declares her father a danger to her as knowing it. For, if a patient believes p , she most likely has reliably formed that belief and, given statistics, p is likely to be true.¹⁵¹

¹⁴⁷ See *supra*.

¹⁴⁸ Lieberman (2007), p.24.

¹⁴⁹ Potter (2007), p.19.

¹⁵⁰ Potter (2007), p.21-2.

¹⁵¹ Potter (2007), p.20; she continues:

Reliabilism requires counterfactual claims to be true: If it were not the case that it is dangerous for her to be in the same room as her father, the patient would not believe that p . This is because,

To which Freedman (2007b) responds:

... as a method for producing beliefs, the trauma of sexual violence does not result exclusively in true beliefs. But that is not the claim I defend in my paper. Rather, I argue that a traumatic experience is a reliable way of forming beliefs, which is to say that it results in a greater proportion of true beliefs than false ones.¹⁵²

E.2: Problematic aspects of the analysis

In an attempt to gain some clarity into this dialogue, a comment by Papineau (2006) (*supra*) provided some perspective. Papineau criticised the tendency within philosophy “... to assess philosophical theories by the extent to which they preserve everyday intuitions”; a related tendency towards partiality – *i.e.* the ‘bending’¹⁵³ of philosophical discussion to accommodate beliefs to which either oneself or one’s culture has a prior allegiance – is no less worthy of criticism in that it risks deforming philosophy into an endeavour whose task is the buttressing of the *status quo*. Both Freedman (2007a) and Potter (2007) are, perhaps, guilty of such partiality:

- Freedman (2007a) firstly, by her acknowledgement that “*there are other cases where we want to say that S knows that p, even though S cannot defend her belief*”¹⁵⁴ and secondly, by her misuse¹⁵⁵ of both the reliability criterion and of statistical argument.
- Potter (2007) by seeking – in her discussion of the conditions for knowledge ascription – to differentiate between the theoretical standards applicable to a psychiatrist, and those applicable to one being subjected to a psychiatric diagnosis.

Furthermore the various contributors to the debate seem unaware of the seriousness of the consequences that might flow from the position that they advocate: if one ascribes *knowledge* to one who believes that she has been abused by her father¹⁵⁶ but who cannot give independent evidence of, nor remember anything concerning, such alleged abuse, then it is a necessary consequence of such ascription that the proposition ‘*That father sexually abused his daughter*’ is true. The use of a girl’s discomfiture in the presence of

typically, we can count on our sensory and cognitive processes to produce the belief that *p* when *p* is true and not to produce the belief that *p* when *p* is false.

¹⁵² Freedman (2007b), p.27.

¹⁵³ By ‘*bending*’, in this context, I mean that in the exposition of an argument, the using of lesser standards of criticism and rigour towards that to which one personally inclines.

¹⁵⁴ *Op. cit.*, p.1. [Emphasis added]

¹⁵⁵ See *infra*.

¹⁵⁶ Freedman (2007a) gives as an example of the sexual abuse survivor who (reliably) ‘knows’ that she has been abused: “... *the case of the woman who refuses to remain alone in a room with her father because she is convinced that it would be unsafe, even though she cannot say exactly why.*” (p.9)

her father as veridical of her having been sexually abused is, in the absence of other evidence, reminiscent of the witchcraft trials at Salem.¹⁵⁷

Fortunately the theory of reliabilism requires no such conclusion as a re-examination of the chicken-sexers example will show [E.2.1]. In the light of this re-examination, Freedman (2007a) is revisited [E.2.2] as is Potter (2007) [E.2.3].

E.2.1: ‘Reliability’ in the context of the chicken-sexers

The chicken-sexers had the ability to reliably sort chickens by sex without knowing how they were able to accomplish this task; their ‘reliability’, however, did not simply reside in their own belief but was securely based in objective evidence: in, for example, customer reports concerning the proportion of chickens that had been described as ‘female’ by the chicken-sexers, who matured into hens.

Assume, for the sake of argument, that the mechanism whereby the chicken-sexers were able to sort the chickens was – unknownst to them – smell. Had they known that this was the case they could – if challenged on their belief that they could determine the sex of chickens – have offered it as a justification for their belief. In the absence of this knowledge they could offer no justification.

‘Reliabilism’ offers an alternative to the need to justify, in that the proven past ability of the chicken-sexers to sort chickens can be offered as a ground for accepting that their current assertion (that a particular chicken is female) is true. It should be noted that ‘reliabilism’ relates, or adheres, to the beliefs of a particular individual not to a particular type of belief: it is not that anyone who believes that they have the ability to determine the sex of a chicken, should be treated as knowing the sex of the chicken, it is rather that one who has consistently demonstrated a proven ability to determine the sex of chickens, should – when they assert that they believe that a particular chicken is female – be regarded, on the grounds of their reliability, as knowing that the facts are as claimed.

E.2.2: Problematic aspects of Freedman’s (2007a) analysis

Freedman (2007a) asserts that the theory of reliabilism obliges us to accept the testimony of one who believes that she has been sexually abused as true even in the absence of any other confirmatory evidence. How does she demonstrate the reliability of their belief?

Surprisingly the proffered evidence is not individual specific but belief specific: it is not that the individual sexual abuse survivor should be regarded as being reliable in relation

¹⁵⁷ As portrayed in Arthur Miller’s play *The Crucible*.

to beliefs of this type because of her proven reliability in relation to earlier such beliefs, it is that beliefs of this type are to be regarded as reliable, a reliability demonstrated by:

The evidence for this new set of beliefs is found in the universality of the everydayness of sexual violence, in particular against women and girls. As Amnesty International states ... violence against women is “*the most outrageous human rights scandal of our times*,” and sexual violence against women is universal.¹⁵⁸

Freedman (2007a) then cites statistics on the prevalence of sexual abuse [e.g. “... in Turkey 35.6% of women have experience marital rape ‘sometimes’ and 16.3% have experienced it ‘often’”]¹⁵⁹ and continues:

The facts on sexual violence against women, as evidenced by these statistics, go to show that the beliefs formed in the aftermath of sexual violence are indeed reliably formed, that is, likely to be true.

The statistics cited by Freedman (2007a) are not relevant to the problem at hand¹⁶⁰ in that they say nothing about the proportion of women who believe they have been abused (but are unable to justify their belief) but who have subsequently been shown to have been abused; Freedman (2007a), in the development of her argument, does not even appear to be aware of the need for any such statistic.

E.2.3: Problematic aspects of Potter’s (2007) analysis

Potter (2007) validates the “*gut feeling*” of the psychiatrist who on the basis – not of a proven – but of a (presumed) reliability.¹⁶¹ But, as concluded in Appendix F, clinical ‘gut feelings’ are of such doubtful reliability that they could not support an application of the doctrine of reliabilism.

The modern movement towards evidence-based medicine evolved precisely because of the proven discordance between the results of interventions based solely on clinical intuition and those based on more scientific foundations.¹⁶² Thus the reliability so readily granted by Potter (2007) may be more illusory than real and may rest more on status than science.

‘Reliabilism’ requires that the claimed reliability be demonstrated: if the psychiatrist can explicitly show that his ‘gut feeling’ diagnosis of malingering has, in the past, been shown, by independent examination, to have been correct, then under the theory of

¹⁵⁸ *Op. cit.*, p.6.

¹⁵⁹ *Ibid.*

¹⁶⁰ Freedman’s misuse of statistics is not uncommon in psychiatry. [See Appendix F]

¹⁶¹ Potter (2007) *supra*; ‘presumed’ in that she states: “*The reliability, in this case, most likely rests on the attending’s longterm observation ...*” (*supra*) [Emphasis added].

The psychiatrist appears to be exempted, on a *a priori* grounds, from her contention that “*without knowing how a belief was formed, [one] ... is not in a position to decide whether or not the process was reliable.*” (*supra*) [Generalised]

¹⁶² See, for example, Sackett (1996).

reliabilism, he can indeed rightly claim to ‘know’ that the patient is malingering; but equally the patient: if he can explicitly demonstrate that his ‘gut feeling’ on the matters at issue, has never mislead him before, then he too can rightly claim to ‘know’. A doctrine such as espoused by Potter (2007)¹⁶³ which discriminates between individuals – not on the evidence than can be adduced in favour of their beliefs – but on the basis of their status cannot be sustained;¹⁶⁴ its application in relation to a possible psychiatric misdiagnosis would permit a psychiatrist’s ‘gut feeling’ to trump a reasoned, evidence-based, challenge.¹⁶⁵

E.3: Delusions of infidelity in the light of reliabilism

In an attempt to contrast the philosophical analysis of an unjustified belief in marital infidelity with that of an unjustified belief in sexual abuse, two scenarios are described in E.3.1; a philosophical response is given in E.3.1.1 and a psychiatric response, in E.3.1.2.

Two additional scenarios are described in E.3.2; a philosophical response is given in E.3.2.1 and a psychiatric response, in E.3.2.2.

E.3.1: Two scenarios

Consider the following two scenarios:

Scenario A: A psychiatrist is confronted by a father and daughter. The daughter alleges that she had been sexually abused by her father when she was a child, the father alleges that these continued allegations have made his life intolerable.

The psychiatrist asks the woman for evidence to substantiate her belief; she replies that she has no memory of such abuse and no evidence other than her unshakeable belief that such abuse had occurred.

Scenario B: A psychiatrist is confronted by a husband and wife. The husband alleges that his wife has been unfaithful; the wife alleges that these continued allegations have made her life intolerable.

The psychiatrist asks the husband for evidence to substantiate his belief; he

¹⁶³ Potter had argued that a patient, in contrast to a psychiatrist, should be required to provide justification for their beliefs. [Potter (2007), p.21-2.]

¹⁶⁴ Two individuals A and B who encounter each other socially, discuss their differing beliefs. Clearly in relation to assessing the rationality of their beliefs they should each be subjected to the same standard. Next change the environment: A is now a psychiatrist and B is a father who is obliged to consult A in relation to child custody hearings. B has had no psychiatric history nor has he been considered by others or by himself as having any mental illness, yet – according to Potter (2007) – B is now to be held to a far higher standard than is A.

¹⁶⁵ *Z. v Khattak & Anor* (2008) [See Introduction] may provide an example of such a scenario.

replies that although there are many subtle signs that substantiate his belief, he has no definitive evidence but nonetheless his belief that his wife has been unfaithful, is unshakeable.

I wish compare and contrast how philosophers such as Freedman (2007a), and psychiatrists such as Fulford (2006), might respond to these scenarios.

E.3.1.1: The philosophical response

Scenario A

Both Freedman (2007a) and Lieberman (2007) would accept the strength of the daughter's belief as being veridical. Potter's (2007) view would apparently differ depending on whether or not the daughter was being interviewed by a psychiatrist:

- *interviewed by a psychiatrist*: the daughter would be required to provide reasons for her belief; her inability to do so would presumably leave her susceptible to a diagnosis of delusion.¹⁶⁶
- *interviewed by a non-psychiatrist*: Potter would not accept that the daughter could be said to 'know' of her supposed abuse, but does not suggest that any negative conclusion in relation to the daughter's mental competence (such as that she might be suffering from delusions) be drawn; her position would appear to be one of suspended judgement.

Scenario B

Freedman (2007a) might seek to distinguish the nature of the evidence that might be adduced in support of the daughter from that of the husband and argue that there is evidence that the daughter's testimony is reliable whereas there is no such evidence in relation to the husband. Pressed further, she could exhibit the statistics in relation to female sexual abuse. However the statistics in relation to female marital infidelity¹⁶⁷ are not only more relevant but more persuasive of the reliability (in the sense used by Freedman) of the husband's belief.¹⁶⁸ In conclusion, she would be obliged to conclude that the husband could be said to *know* that his wife was unfaithful.

¹⁶⁶ The unorthodoxy criterion in relation to delusion (*i.e.* the condition that the belief be not widely shared) is satisfied: "... *the picture of the world that it [GR: *i.e.* sexual abuse] paints is one that is routinely dismissed by our contemporary culture that keeps well hidden the universality of sexual violence against women.*" [Freedman (2007a), p.8]

¹⁶⁷ See Appendix D.

¹⁶⁸ As is the report by Mullen (1990) *supra*:

Cases where accusations which appeared delusional are emphatically denied by the partner and unsupported by any tangible evidence, but are eventually confirmed by events, are not uncommon in the experience of clinicians with an interest in jealousy.

Potter, in the scenario as painted (*i.e.* a psychiatric interview) would require the husband to provide reasons for his belief; his inability to do so would presumably leave him susceptible to a diagnosis of delusion.

E.3.1.2: The psychiatric response

Fulford's analysis of delusion does not offer any mechanism whereby the scenarios can be distinguished.¹⁶⁹ To be consistent, Fulford must accordingly conclude that the daughter [*Scenario A*] and the husband [*Scenario B*] are both delusional.

E.3.2: Two further scenarios

*Scenario A**: The same as Scenario A but the psychiatrist now knows that the daughter had in fact been abused as a child (the father having earlier confessed this to the psychiatrist).

*Scenario B**: The same as Scenario B but the psychiatrist now knows that the wife had in fact been unfaithful (the wife having earlier confessed this to the psychiatrist).

E.3.2.1: The philosophical response to the revised scenarios

The conclusion that the daughter *knows* that she has been abused, could only be strengthened in the revised scenario.

E.3.2.2: The psychiatric response to the revised scenarios

The revised scenarios would not materially affect Fulford's (2006) view¹⁷⁰ who must again conclude that the daughter was delusional.

E.4: A philosophical double standard?

The stance adopted by some philosophers towards women who have an unshakeable, but unjustifiable, belief that they have been sexually abused by their fathers, is – when contrasted by the philosophical stance adopted towards husbands who have an unshakeable, but unjustifiable, belief that their wives have been unfaithful – indicative of a lack of impartiality which manifests itself in an *a priori*, willingness to come to the defence of current psychiatric practice.

¹⁶⁹ It should be noted that any presumptions as to the dangerousness of one diagnosed as suffering from delusions of infidelity, can only logically come into play once the issue of delusion has been resolved.

¹⁷⁰ *Vide* Fulford's (2006) example (*supra*) of the publican with delusions of infidelity.

Section F: Chapter Conclusions

The following questions were posed at the start of this chapter:

Question 4: Is the psychiatric definition of delusion coherent?

Question 5: Does the psychiatric diagnosis of a subject as ‘delusional’ necessarily imply that the subject is irrational?

Question 6: Do gradations of delusion correlate with levels of irrationality in such a manner that the gravity of a delusion which is sufficient on its own¹⁷¹ to (as adjudged by psychiatrists) warrant a coercive intervention, corresponds to a level of irrationality sufficient to put personhood in jeopardy?

Question 4 will be addressed in Subsection F.1; questions 5 and 6, in Subsection F.2.

F.1: Question 4

David’s (1999) description (*supra*) of the psychiatric definition of delusion as a “shambles”, is perhaps overly polemic and – in that he was speaking of the conflation of both the *DSM-IV-TR* (2000) and clinical definitions – it is wise to consider these definitions separately when considering questions of coherence.

F.1.1: The coherence of ‘delusion’: the *DSM-IV-TR* (2000) definition

Drury (1996), in discussing the logical or philosophical infelicities to which medicine – and especially his own discipline of psychiatry – was prey, spoke of what he termed the “fallacy of the missing hippopotamus”¹⁷² which concerned the use of “fact proof” propositions that can neither be verified nor refuted: “But that which cannot be proved wrong by any conceivable experience is without meaning.”¹⁷³ Drury’s fallacy is of assistance in discussing the coherence of the psychiatric concept of delusion.

Aside from problems associated with the orthodoxy of a belief¹⁷⁴ the *DSM-IV-TR* (2000) definition of delusion has, at first glance, the appearance of rigour and coherence but the test of such a definition lies in how it is implemented by those who are accorded the authority to interpret it, *i.e.* psychiatrists.¹⁷⁵

¹⁷¹ *i.e.* without recourse to assessments of dangerousness to others.

¹⁷² *Op. cit.*, p.16:

There is an hippopotamus in this room at this minute, but no one can see it, no one can hear it, no one can smell it, no one can touch it: have I now with all these added provisos said anything meaningful at all?

¹⁷³ *Op. cit.*, p.17.

¹⁷⁴ And concomitant problems concerning ‘normalcy’ (*supra*).

¹⁷⁵ Much as the interpretation – and coherence – of a legal definition lies not in what a particular statute might say but in how it is interpreted by the courts.

The psychiatric testimony given during the trial of Zacarias Moussaoui,¹⁷⁶ provides an example of how the *DSM-IV-TR* (2000) definition is interpreted in practice; this example is particularly authoritative in that a diagnosis of delusion made by an eminent psychiatrist,¹⁷⁷ was being defended by him in a highly controversial case subject to intense media scrutiny. Dr. First had diagnosed Moussaoui as suffering from paranoid and grandiose delusions one of which was that he would be freed by President Bush; in testimony, First contended that Moussaoui's belief was so highly improbable as to be false. The psychiatrist testifying for the prosecution refused to concede that Moussaoui's belief was irrational, and suggested that it was not implausible that Moussaoui might be freed as part of a hostage exchange.¹⁷⁸

An application of Drury's test (*supra*) suggests the question: "*What facts would be required to determine whether or not Moussaoui's belief was delusional?*" The extreme difficulty, if not impossibility, of indentifying – let alone determining – any such facts places a considerable obstacle in the face of anyone who seeks to argue for the coherence of the *DSM-IV-TR* (2000) definition of delusion.

The problem of coherence becomes even more intractable when the falsity test is replaced by the justification test (*supra*) as occurs in the clinical definition.

F.1.2: The coherence of 'delusion': the clinical definition

The example of a husband who was unshakeably convinced that his wife was unfaithful yet who was unable to justify this belief to the satisfaction of a psychiatrist and who was accordingly diagnosed as delusional, has been discussed in earlier sections and is often cited in the psychiatric literature as a paradigm of delusion; the gloss that the psychiatrist knew that the wife was, in fact, unfaithful is often added¹⁷⁹ as a means of emphasising its irrelevance to the diagnosis and of distinguishing the 'falsity criterion' from the 'justifiability criterion.' In none of the psychiatric texts on delusion that I have consulted has such use of the 'justifiability criterion' been criticised, on the contrary it has been regarded as self-evidently appropriate.

In the course of the chapter I have sketched two other scenarios:

¹⁷⁶ *USA v Zacarias Moussaoui* (2002); Moussaoui was charged with withholding information in relation to the September 11th 2001 attacks on the US. The case is discussed in Appendix F.

¹⁷⁷ Dr. First was editor of the *DSM-IV-TR* (2000).

¹⁷⁸ Referring to the Reagan era Iran-Contra scandal, he said: "*I know we traded arms for hostages*". See Appendix F.

¹⁷⁹ See for example, Fulford (2006), p.43.

- that of a teacher who confides her unshakeable but unjustifiable belief that a colleague was sexually abusing a pupil, to her headmaster (who was independently aware of the truth of the allegation);
- that of a young woman who confides her unshakeable but unjustifiable belief, that she had been sexually abused by her father, to her psychiatrist (who was independently aware of the truth of the allegation).

Applying a variant of Drury's test (*supra*) one might ask as to what possible fact might serve to distinguish these scenarios from that of the jealous husband, so that the husband would be delusional but not the teacher or young girl?

The fact that none of the definitional criteria can serve to distinguish these cases suggests that what is being offered as a definition of delusion is not a definition but rather a permissive mechanism which will enable its discretionary application in situations where a psychiatrist deems that other, unstated, circumstances warrant its use.¹⁸⁰ Such a conclusion threatens the very coherence of the psychiatric concept of delusion.

F.2: Questions 5 and 6

The discussion on the clinical definition of delusion in this chapter has – for reasons mentioned earlier – focused on delusions of infidelity. The psychiatric concept of delusion encompasses many more delusions¹⁸¹ than those of infidelity¹⁸² and doubtlessly many holding such delusions – and indeed many holding delusions of infidelity – manifest extreme levels of irrationality even approaching a gravity sufficient to put personhood in jeopardy. However the problem posed by questions 5 and 6 does not require an examination of such delusions: the problem centred on

- whether a subject who was diagnosed as delusional, *necessarily* manifested irrationality and, if so,

¹⁸⁰ On delusions generally:

- see, for example, Spitzer (1990) (*supra*): “*In many cases the clinician cannot actually disprove the claims of the patients, but nevertheless wants to describe certain phenomenon as delusions.*” p.379 [Emphasis added].

In relation to claims of sexual abuse (*supra*):

- Freedman (2007a): “*But there are other cases where we want to say that S knows that p, ...*” (p.1) [Emphasis added].

- Potter (2007): “*Yet her claims are important because, as Freedman states, “... [k]nowledge is a success term’ (10) and to identify the victim of sexual violence as a knower is a hard-won compliment.”*” (p.20) [Emphasis added].

¹⁸¹ See, for example, some of the classic delusions described by Davies & Coltheart (2000) (p.1 *et seq.*)

- My closest relatives have all been replaced by impostors. (*Capgras Delusion*)

- I am dead. (*Cotard delusion*)

- I am being followed by people known to me but in disguise. (*Fregoli delusion*)

¹⁸² Though delusions of infidelity command a prominent place in the literature on delusions.

- whether if the diagnosis of delusion precipitated a coercive psychiatric intervention, the gravity of the irrationality implicit in the delusion was sufficient to put personhood in jeopardy.

Delusions of infidelity provide a more than adequate testing ground for the resolution of these problems.¹⁸³

Within this context, questions 5 and 6 resolve into two simpler questions:

- Is one who has an unshakeable but unjustifiable¹⁸⁴ belief necessarily irrational?
- Can the holding of such a belief precipitate a coercive psychiatric interventions?

In addressing these questions, it is important (as discussed earlier) to make the distinction between ‘holding’ a belief which is not capable of justification and insisting that others share that belief. Whereas it may well be reasonable to insist of such an advocate that they demonstrate their reasons for holding their belief – and to judge their inability to provide such reasons, ‘irrational’ – it is by no means clear that the same analysis applies to one who simply cleaves to his own private belief which he is unable to justify. The point is of importance since, for example, in cases such as Blehein’s it seems he was not seeking to persuade the doctor of his belief but simply to inform him of its existence.

In relating to the simple cleaving steadfastly to an unjustified belief, I suggest that the discussion earlier in this chapter (and cases such as Blehein’s) support the conclusion that the diagnosis of a delusion, which precipitates a coercive intervention, may occur in cases where the subjects manifests minimal, if indeed any, irrationality let alone irrationality of a degree sufficient to justify the putting of personhood in jeopardy.

¹⁸³ The fact that a diagnosis of delusion of infidelity often precipitates a coercive psychiatric intervention has been adverted to earlier in this chapter.

¹⁸⁴ Other than a religious belief or one which is generally shared.

Chapter 4: Problematic aspects of psychiatric diagnosis

... Words strain,
Crack and sometimes break, under the burden,
Under the tension, slip, slide, perish,
Decay with imprecision, will not stay in place,
Will not stay still. Shrieking voices
Scolding, mocking, or merely chattering,
Always assail them.

Lines from a poem by T S Eliot¹

Ideally, the conclusion to this chapter would answer the question:

What proportion of coercive psychiatric interventions are grounded in an erroneous psychiatric diagnosis?²

The answer to such a question clearly has a direct relevance to assessments of proffered justifications for a coercive psychiatric intervention.

It also has an indirect relevance in that it enables the diagnosing psychiatrist to be questioned as to his awareness of the likelihood of a diagnosis such as his, being erroneous. Consequently it permits a conclusion to be drawn as to the reliability of a psychiatrist's professional opinions in much the same way as if, during a criminal trial, a fingerprint expert definitively identified a suspect's fingerprints with those found at the scene of the crime, yet was unaware of the error rate of similar 'definitive' identifications.

Similar problems (which also have both a direct and indirect relevance to assessing justifications for coercive intervention) are posed in subsequent chapters: the proportion of psychiatric treatments that cause iatrogenic³ harm [[Chapter 5](#)]; the proportion of coercive psychiatric interventions that are based on erroneous assessments of dangerousness [[Chapter 6](#)].

Some studies on the levels of misdiagnosis and of iatrogenic harm occurring in general (non-psychiatric) medicine are examined in Appendix I where it is concluded that:

¹ Lines from *The Four Quartets*. [Eliot (1944), p.8.]

² In the sense that had the erroneous diagnosis not been made the coercive intervention would not have occurred. Two supplemental questions must also be posed:

- (i) Are the criteria underpinning a psychiatric diagnosis of a rigour sufficient to retrospectively determine whether a particular psychiatric diagnosis was a misdiagnosis?
- (ii) Do psychiatrists in their clinical practice, manifest an awareness of the probability of making a psychiatric misdiagnosis?

The latter is relevant to the general reliability of psychiatric assessments.

³ *I.e.* harm inadvertently caused by medical treatment.

- the level of non-psychiatric misdiagnosis is of the order of 25%; the misdiagnosis rate in Irish psychiatric practice is likely to exceed this due to the presence of a number of factors (some peculiar to psychiatry, some to the practice of medicine in Ireland and some to both).⁴
- the rate of iatrogenic harm occurring in Ireland is at least comparable to that found in the US which is 3.7% of all admissions [Brennan(1991)]⁵.

Furthermore, any attempt at simply transposing misdiagnosis estimates from general medicine, to psychiatry would be premature if for no other reason than because, in psychiatry, the term ‘misdiagnosis’ has a number of meanings and these require disambiguation.

To provide a context for this discussion, a classic study of psychiatric misdiagnosis is described in Section A. Some concepts are outlined in Section B and these assist in distinguishing differing meanings of the term ‘misdiagnosis’ [Section C]. Possible methods for estimating levels of psychiatric misdiagnosis are discussed in Section D and Appendix M. Some conclusions are drawn in Section E.

Section A: The Rosenhan experiment

At a time when psychiatry and its diagnostic techniques were under sustained attack, Rosenhan (1973) sought to determine whether psychiatrists could reliably distinguish ‘*the sane*’ from ‘*the insane*’ or whether psychiatric diagnoses flowed more from the context in which psychiatrists encountered their subjects, rather than from any intrinsic characteristic of the subjects themselves.

Rosenhan’s experiment consisted of two parts; the first part is discussed in Subsection A.1; his analysis of the results, in Subsection A.2; the second part of the experiment, in Subsection A.3 and some critical observations in Subsection A.4.

A.1: The first experiment

This part of the experiment sought to get ‘normal’ people admitted to psychiatric hospitals and see if, and how, their sanity was detected:

If the sanity of such pseudopatients were always detected, there would be *prima facie* evidence that a sane individual can be distinguished from the insane context in which he is found.⁶

If, on the contrary, the deception was not uncovered, then:

⁴ *E.g.* the lack of definitive biological tests for psychiatric illness; the lack of effective judicial oversight due to the extreme difficulty in seeking legal redress for psychiatric negligence.

⁵ See the Introduction and Appendix I.

⁶ Rosenhan (1973), p.251.

... such an unlikely outcome would support the view that psychiatric diagnosis betrays little about the patient but much about the environment in which an observer finds him.⁷

Rosenhan and a number of pseudopatients (the majority being psychologists) sought admission into a variety of mental hospitals by arriving at the admissions office complaining that they had heard voices:

Asked what the voices said, he replied that they were often unclear, but as far as he could tell they said “empty,” “hollow,” and “thud.” ... It is as if the hallucinating person were saying, “*My life is empty and hollow.*”⁸

Immediately on admission the pseudopatients ceased displaying any sign of abnormality; they were told that they would be discharged when they convinced the staff that they were sane. Seeking early discharge, they became model patients but, despite this, their deception remained undetected by the staff.

Of the twelve admissions, eleven were diagnosed as schizophrenic and one, “*with identical symptomatology*” as having manic depressive psychosis.⁹

A.2: Rosenhan’s analysis

Rosenhan considered that a possible explanation for these results might lie in a medical propensity to call a healthy person, sick (*i.e.* a false positive) rather than a sick person, healthy (*i.e.* a false negative) because “*it is clearly more dangerous to misdiagnose illness than health. Better to err on the side of caution.*”¹⁰ Rosenhan argues that such a standpoint is not permissible in psychiatry because of the stigmatising effects of a psychiatric diagnosis.¹¹

Rosenhan also noted the imperviousness of a psychiatric diagnosis to attempts at remediation (the phenomena of ‘labelling’) [A.2.1], and the depersonalising effects of a psychiatric diagnosis [A.2.2].

A.2.1: ‘Labelling’

Rosenhan spoke of the “*massive role of labeling in psychiatric assessment*”:¹²

Having once been labeled schizophrenic, there is nothing the pseudopatient can do to overcome the tag. The tag profoundly colors others’ perceptions of him and his behavior. ... Once the impression has been formed that the patient is schizophrenic, the expectation is that he will continue to be schizophrenic. ...

⁷ *Ibid.*

⁸ *Ibid.*

⁹ *Ibid.*, p.252; this diagnosis (which occurred in the only private hospital in the sample) was less stigmatising than a diagnosis of schizophrenia.

¹⁰ *Ibid.* The second part of his experiment is designed to test this hypothesis.

¹¹ *Ibid.*: “*Psychiatric diagnoses ... carry with them personal, legal, and social stigmas.*”

¹² *Ibid.*

Eventually, the patient himself accepts the diagnosis, with all of its surplus meanings and expectations, and behaves accordingly.¹³

But psychiatric diagnoses are rarely found to be in error. The label sticks, a mark of inadequacy forever.¹⁴

A.2.2: Depersonalisation effects of a psychiatric diagnosis

Rosenhan described depersonalisation:

At times, depersonalization reached such proportions that pseudopatients had the sense that they were invisible, or at least unworthy of account. ... A nurse unbuttoned her uniform to adjust her brassiere in the presence of an entire ward of viewing men. One did not have the sense that she was being seductive. Rather, she didn't notice us. ... Reactions to such depersonalization among pseudopatients were intense.¹⁵

The effect of such labelling and depersonalisation on personhood is discussed later¹⁶ where Rosenhan's attempt to quantify the degree of depersonalisation is also examined.

A.3: The second experiment

To test whether the high rate of misdiagnosis could be due to a propensity to err on the side of diagnosing a healthy person, as sick (*i.e.* a false positive), Rosenhan arranged a second experiment at a teaching hospital whose staff had heard of the first experiment and who doubted that they could be similarly misled. Rosenhan agreed that he would arrange for a pseudopatient to seek admission to that hospital within the following three months.

Of 193 patients who were actually admitted to the hospital during that period:

Forty-one patients were alleged, with high confidence, to be pseudopatients by at least one member of the staff. Twenty-three were considered suspect by at least one psychiatrist. Nineteen were suspected by one psychiatrist and one other staff member.¹⁷

In fact no pseudopatients had been sent to the hospital and thus the errors of misdiagnosis committed by this hospital were all false negatives – *i.e.* they diagnosed the sick, as healthy.

¹³ *Ibid.*, p.253-4.

¹⁴ *Ibid.*, p.257.

¹⁵ *Ibid.*, p.256.

¹⁶ Chapter 7.

¹⁷ *Ibid.*, p.252.

A.4: Observations on the Rosenhan study

The study is discussed in A.4.1 as an illustration of the susceptibility of psychiatric diagnosis to the ‘*confirmation bias*’¹⁸; a criticism by Dr. Robert Spitzer, the principal architect of *DSM-III* (1980), is examined in A.4.2.

A.4.1: As an illustration of the ‘confirmation bias’

The first Rosenhan experiment gives a particularly revealing illustration of the confirmation bias as it manifests itself in psychiatric practice: the psychiatric diagnosis, once made, acted as a distorting filter and the information that was allowed through the filter was reconfigured to preclude a disconfirmation of the diagnosis:

... the perception of his circumstances was shaped entirely by the diagnosis. ... The facts of the case were unintentionally distorted by the staff to achieve consistency with a popular theory of the dynamics of a schizophrenic reaction. ... the meaning ascribed to his verbalizations ... was determined by the diagnosis: schizophrenia. An entirely different meaning would have been ascribed if it were known that the man was “*normal*.”¹⁹

Rosenhan cites the example of a pseudopatient whose note-taking (in being described by the phrase: “*Patient engaged in writing behaviour.*”) took on pathological overtones.²⁰ Even the most mundane behaviour was capable of such misinterpretation:

One psychiatrist pointed to a group of patients who were sitting outside the cafeteria entrance half an hour before lunchtime. To a group of young residents he indicated that such behavior was characteristic of the oral-acquisitive nature of the syndrome. It seemed not to occur to him that there were very few things to anticipate in a psychiatric hospital besides eating.²¹

The second experiment also shows the effect of preconceptions (*i.e.* the belief that pseudopatients would present) on psychiatric diagnosis but this time the errors were in the opposite direction to those in the first experiment.

Considered as one, the experiments point to the confirmation bias as being the most plausible explanation for the high rate of misdiagnosis.²²

A.4.2: Spitzer’s criticism

Spitzer argued²³ that if a subject were to drink a quart of blood and, having concealed what he had done, present at a hospital accident department vomiting blood, the

¹⁸ The ‘confirmation bias’ [see Chapter 3] describes the tendency to seek and find confirmatory evidence in support of existing beliefs and to ignore or reinterpret disconfirmatory evidence.

¹⁹ Rosenhan (1973), p.253.

²⁰ *Ibid.*: “*Nursing records for three patients indicate that the writing was seen as an aspect of their pathological behavior.*”

²¹ *Ibid.* Compare Bentall’s observation on the psychiatric assessment of a patient: “*He’s excessively polite,*” the nurse explained darkly. ... “... *we’re trying to work out whether his politeness is part of his normal personality or his illness.*” [Bentall (2009), pp.111-2; see also Chapter 7]

²² See also the discussion later in this chapter on ‘information cascades’.

behaviour of the staff would be quite predictable. If they diagnosed and treated the subject as having a peptic ulcer, could one maintain that (non-psychiatric) medical diagnosis lacked rigour?

In relation to the first of Rosenhan's experiments, Spitzer's argument has a degree of cogency but only succeeds in being a rebuttal of the more extreme interpretations provided that the possibility of coercion is omitted from the discussion. Once the possibly coercive nature of a psychiatric intervention is addressed, Spitzer's argument loses its purchase: consider an old man brought to a mental hospital by relatives who assert that he is mentally confused. If admitted, then the situation as portrayed by Rosenhan would unfold according to its own ineluctable 'logic'; he would be inexorably trapped within the 'Catch 22' of his diagnosis.²⁴ As described by Rosenhan, it is not even necessary for the initial hospitalisation to have been involuntary.²⁵

Since the introduction of the *DSM-III* and *DSM-IV* psychiatric diagnostic practices have become more subtle and sophisticated than they were in 1972 and it may well be argued that the Rosenhan's experiment no longer has relevance. Precisely this point was made by Spitzer in an interview with the writer Lauren Slater: "*I'm telling you, with the new diagnostic system in place, Rosenhan's experiment could never happen today.*"²⁶ Slater attempted to repeat Rosenhan's experiment and she documented her experiences²⁷ which although it has none of the rigor of Rosenhan's work, is of interest for her interview with Spitzer.

²³ Spitzer (1975) and Spitzer (1976).

²⁴ Chekhov's short story 'Ward No. 6' portrays such a situation in which a doctor is involuntarily committed to a mental asylum, his protestations of sanity only serving to further ensnare him:

When people tell you that you have diseased kidneys or an enlarged heart and you go and have treatment, or if you're told you're insane or a criminal – in a word, when people start taking notice of you – then you can be certain you've fallen into a vicious circle from which there's no escape. And the more you try to escape, the more you get caught up in it. One might as well give in, since no human efforts can save you.

[Chekhov (2003), p.78.]

The Manweiler [Appendix H] and Juklerød [Appendix G] cases exemplify not dissimilar scenarios.

²⁵ Rosenhan (1973), p.258:

... once admitted to a psychiatric institution, it is difficult, if not impossible, to be discharged on short notice, state law to the contrary notwithstanding. I was not sensitive to these difficulties at the outset of the project, nor to the personal and situational emergencies that can arise, but later a writ of habeas corpus was prepared for each of the entering pseudopatients and an attorney was kept "on call" during every hospitalization.

See also the Manweiler case, though Manweiler entered hospital as a voluntary patient he was (unlawfully) made involuntary. [See Appendix H].

²⁶ Slater (2005), p.80.

²⁷ *Ibid.*

Spitzer had told her:

According to Rosenhan all the patients were diagnosed at discharge as '*in remission*'. A remission is clear. It means without signs of illness. Thus all of the psychiatrists apparently recognised that all of the pseudopatients were, to use Rosenhan's term, 'sane'.²⁸

Spitzer's attempt to equate:

- '*X had schizophrenia but it is now in remission*', and
- '*X's sanity is unquestionable*.'

by means of an intermediate step ('*X is sane*') to which they are individually equated, smacks of sophistry and is an unworthy response to Rosenhan's arguments.

Slater attempted to gain admission to nine psychiatric hospitals, each time she was unsuccessful²⁹ but most times she was given a diagnosis of "*depression with psychotic features*"³⁰ and prescribed antipsychotics and antidepressants. On informing Spitzer of the results of her 'experiment', she describes his reaction: "*I'm disappointed*," he says, ... "*I think doctors just don't like to say, 'I don't know'*."³¹

Section B: Some concepts relevant to a discussion of psychiatric misdiagnosis

The controversy surrounding Rosenhan (1973) and similar studies; the unremitting criticism of conventional psychiatric practice by psychiatrists such as Szasz and Laing, and the existence of gross disparities between the diagnostic rates prevailing in England and the US, for conditions such as schizophrenia,³² became a source of scandal and led to calls for reform which resulted in the publication of a new edition of the *DSM* – the *DSM-III* (1980) – whose goal was the achievement of '*diagnostic reliability*.'³³ Though sanctioned by usage, the term '*reliability*' may connote notions of '*validity*' from which it should be distinguished;³⁴ a more appropriate terminology would be '*diagnostic*

²⁸ *Ibid.*, p.75.

²⁹ The straightened financial circumstances of the Health Services may have contributed to her being refused admission. In view of the 'classic' status in psychiatry of the Rosenhan experiment, her describing the voice as saying '*thud*' might have been expected to raise suspicions; apparently it did not.

³⁰ *Ibid.*, p.88.

³¹ *Ibid.*, p.90.

³² Cf. the quip by Anthony Clare that the easiest way to cure an American diagnosed with schizophrenia was to send him to England. [Clare (1980), p.129]

See also Cooper (2003):

In 1961 ... [in the] admission statistics to State mental hospitals in the USA, the rates for schizophrenia for most age groups were about five times those in the UK, and for some age groups other differences were as much as twenty times.

³³ See Kirk & Kutchins (1994), p.71-86.

³⁴ To say, for example, that '*X is reliably diagnosed as having psychiatric condition Z*' would appear to carry the implication that '*X is reliably diagnosed as being mentally ill*' yet it actually means no more than that psychiatrists would generally concur that X satisfied the diagnostic symptom checklist for Z.

consistency: *i.e.* that individual psychiatrists would agree on the diagnostic category in which to place any particular subject.

Kirk & Kutchins (1994) note that concentrating on problems of reliability:

... make it possible to forget about the messy problems of validity. ... Reliability problems can be reduced to questions about techniques of decision-making, in contrast to validity problems, which must answer complex philosophical and theoretical questions.³⁵

In addition to ‘reliability’ and ‘validity’, the concept (which I have earlier termed)³⁶ ‘*psychiatric pre-diagnosis*’ is also of use in discussing misdiagnosis; it refers to the categorisation of a problem as a ‘psychiatric problem’, *i.e.* a problem whose locus lies in one individual and which is amenable to a psychiatric resolution; such a characterisation is equivalent to a declaration that the individual in question is ‘mentally ill’.³⁷

An example given by Kirk & Kutchins (1994)³⁸ shows the interrelatedness of these concepts: if, in the 1970s, a psychiatrist became aware that an individual being interviewed by him was homosexual, the psychiatrist was tasked with first determining whether this should be construed as a psychiatric problem [the ‘pre-diagnosis’] thus rendering the subject ‘mentally ill’; if so, he then had to diagnose whether the individual actually met the diagnostic criteria for homosexuality [*e.g.* “exclusively homosexual activity for a period of at least ...”]. Different psychiatrists might diagnose homosexuality differently [one might regard such activity in a teenager as explorative rather than definitive]. To resolve such problems of reliability, the American Psychiatric Association (APA) – the editors of the *DSM* – might appoint a committee to more accurately specify the diagnostic criteria for homosexuality; this however, would leave unresolved the deeper question of whether someone presenting as homosexual should be regarded as mentally ill or indeed whether homosexuality should be regarded as a valid psychiatric diagnosis. This latter raises a further question: who has ‘ownership’ of determinations of validity?³⁹ Is it the profession of psychiatry or is it the

The validity of Z – *i.e.* that Z is correctly designated as being a ‘mental illness’ – is logically independent of diagnostic reliability.

³⁵ *Op. cit.*, p.33.

³⁶ See Chapter 3.

³⁷ It is possible to speak of the act of pre-diagnosis as a ‘diagnosis’ of mental illness but this would create a further ambiguity and I have reserved ‘diagnosis’ for the processes which assigns a subject to a particular diagnostic category (corresponding to the use of the term ‘diagnosis’ in non-psychiatric medicine).

³⁸ *Op. cit.*, p.33.

³⁹ See (2004), p.82: “*Qu'est-ce que c'est, être fou? Qui en décide? Depuis quand? Au nom de quoi?*” [“*What is it to be mad? Who decides? Since when? In the name of what?*” C. O’Brien (trans.)]

general public?⁴⁰ This question indirectly challenges the status of psychiatry and, more particularly, its claim to ‘scientific’ status. To those who regard psychiatry as a science, issues concerning the validity of particular diagnostic categories are technical questions requiring a specialist knowledge of psychiatry for their resolution much as, for example, the classification of a particular organism as belonging to one particular species is a matter that falls to be decided by professional biologists. However, to critics of mainstream psychiatry (such as Szasz), these are issues to which psychiatry brings no especial expertise and which should be resolved through informed public debate.

A substantial literature exists on the above concepts but they will be discussed only to an extent sufficient to illustrate some of their more problematic aspects in so far as these might bear on misdiagnosis; ‘psychiatric pre-diagnosis’ is discussed in *Subsection B.1*; ‘reliability’, in *Subsection B.2*; ‘validity’, in *Subsection B.3* and the scientific status of psychiatry, in *Subsection B.4*.

*B.1: Psychiatric pre-diagnosis*⁴¹

Psychiatric pre-diagnosis refers to the process whereby it is determined that the locus of a problem resides in a particular individual rather than with their family, their immediate social group or the wider society;⁴² thus in the Blehein case⁴³ the pre-diagnosis refers to the decision to treat the husband’s belief that his wife was unfaithful as a psychiatric problem justifying a psychiatric committal rather than one which might have been more appropriately tackled by either family therapy or by marital separation. Similarly in the Manweiler case⁴⁴ a resolution might have been found in improved family communication⁴⁵ rather than in a coercive psychiatric intervention focusing on just one family member.

Speaking of his homosexuality, Foucault stated: "*Very quickly, it turned into a kind of psychiatric threat: if you are not like everyone else you are abnormal, if you are abnormal it means you are ill.* [Foucault (2004), p.95; see also Chapter 3].

⁴⁰ In 1974 the APA decided – by a ballot of its members and in response to intense lobbying by interest groups external to psychiatry – to reverse its earlier position that homosexuality was deemed to be a mental illness.

⁴¹ See also the discussion of psychiatric pre-diagnosis in Chapter 3; Smith’s (1978) analysis is of particular relevance in the present context.

⁴² See, for example, Luhrmann (2010) who, in discussing the gross overrepresentation of racial minorities in those diagnosed with schizophrenia (see *infra*), asks:

There is something about social defeat that gets under the skin and – in those who are vulnerable – can literally drive someone crazy. ... Why is it that racial prejudice – which certainly exists – seems so much more palatable as an explanation for high rates of illness than the effects of social inequality? [p.480]

⁴³ See Chapter 3.

⁴⁴ See Appendix H.

⁴⁵ As recommended in the report of the hospital psychologist; it made no mention of Manweiler being ‘mentally ill’. [See Appendix H]

A psychiatric pre-diagnosis is equivalent to a determination that the subject is ‘mentally ill’ and at first glance it might seem that the concept is otiose in that (psychiatric) diagnosis is – in Austin’s phrase – the ‘trouser-word’ and hence that unambiguous diagnostic criteria would conclusively determine the pre-diagnosis; an examination of some individual cases⁴⁶ shows this not to be the case in that the grounds offered in justification of the coercive intervention were vague and not grounded in specific diagnostic criteria. Indeed aspects of Irish psychiatric practice⁴⁷ and studies such as Rosenhan (1973) suggest that it is ‘pre-diagnosis’ rather than ‘diagnosis’ that is the trouser-word.

Some general factors which predispose towards psychiatric pre-diagnosis are discussed in B.1.1; some particular factors, in B.1.2; the term ‘mental illness’ is then examined [B.1.3] to see if it helps explicate the concept of psychiatric pre-diagnosis.⁴⁸

B.1.1: General factors favouring psychiatric pre-diagnosis

Reich (1999) in his examination of the social role played by psychiatric diagnosis⁴⁹ – an analysis which Fulford (2006) describes as “*a scholarly tour de force*”⁵⁰ – speaks of “*the beauty of diagnosis as a solution to human problems*”;⁵¹ its “*most fetching beauty*” being:

... its capacity to instantly explain behaviour that is odd, objectionable, troublesome, or illegal, can be through the mediation of diagnosis, suddenly be (*sic*) understood, explained, and explained away.

To be sure, such behaviour may indeed be the product of diagnosable mental illness. But the capacity of a diagnosis to perform this function makes its use a temptation even in cases in which such illness does not exist or, at best, is only marginally present.⁵²

It also embodies other ‘beauties’:

... its power to reassure. When acts are committed whose implications are disturbing – acts that suggest vulnerabilities in ourselves, our institutions, or our

⁴⁶ *E.g.* the Amy or Manweiler cases.

⁴⁷ MHC (2005), p.40:

Unfortunately, 15% of residents had no diagnosis returned. This is due in large part to the practice in some inpatient facilities of not recording a diagnosis until discharge. As this is a census, the residents have not yet been discharged and therefore have no recorded diagnosis.

⁴⁸ In that a pre-diagnosis entails an ascription of mental illness.

⁴⁹ Reich (1999) uses the term ‘diagnosis’ in the sense of ‘pre-diagnosis’.

⁵⁰ *Op. cit.*, p.579.

According to Fulford: “*Reich ... is among the few, and perhaps the best, of traditional bioethicists to have clearly identified and sought to analyse the central ethical significance of psychiatric diagnosis.*” [*Ibid*, p.587].

⁵¹ Reich (1999), p.205.

⁵² *Ibid*.

communal beliefs – diagnoses ... serve to shift the frame of the behaviour from the threatening personal or social arena to a safer medical one.⁵³

... its power to reclassify whole categories of socially unacceptable behaviour as the products of psychiatrically diagnosable conditions. ... and psychiatrists, whose redefinitions make all this possible, and who can feel themselves in the noble position of healing where others would have only hurt.⁵⁴

Reich is by no means alone⁵⁵ in drawing the conclusion that the act of psychiatric pre-diagnosis may serve to divert attention from family or social factors which a disinterested analysis would see as a more appropriate locus.

B.1.2: Particular factors favouring psychiatric pre-diagnosis

There are also some structural factors which favour a psychiatric pre-diagnosis rather than non-psychiatric mechanisms for the resolution of some social or family problems:

(i) adherence to the principle that it is better to err on the side of making a committal, than not;⁵⁶ this is especially the case under Irish law as the individual seeking the involuntary committal of another may have a cause of action against a GP or psychiatrist who negligently refuses committal (especially if an act of violence is perpetrated by the subject subsequent to the refusal) whereas one subjected to an involuntary committal has no cause of action against a GP or psychiatrist who negligently sanctions a committal.⁵⁷

(ii) under Irish law, the committal procedure only involves GPs and psychiatrists (and not lawyers or judges) and the financial interests of these professions cannot be ignored especially as alternative mechanisms might not involve psychiatrists.⁵⁸

Lest the suggestion that the financial interests of doctors might influence – or that the interests of family members might determine – such decisions, be regarded as unwarranted, might I offer in defence of the former, the practice of GPs prescribing antibiotics in the treatment of viral infections (for which they are not only of no value but may be harmful);⁵⁹ in defence of the latter, the practice of prescribing

⁵³ *Ibid.*, p.208.

⁵⁴ *Ibid.*, p.209.

⁵⁵ See, for example, Johnstone (2000):

The personal meaning of people's distressing experiences and the psychological and social origins of their difficulties are obscured by turning them into the 'symptoms' of an 'illness' located within one individual; ... And politicians of all persuasions have an interest in seeing mental distress as stemming from biological rather than social factors; in arguing, for example, that mental illness causes homelessness rather than, as the evidence actually suggests, that homelessness leads to mental breakdown. [p.201-2]

⁵⁶ See Rosenhan (*supra*).

⁵⁷ See Appendix A.

⁵⁸ See, for example, Melvin (1986) who speaks of the "economic rivalry" between psychiatry and psychology; see also Pingitore (2002).

⁵⁹ Mangione-Smith (1999):

antipsychotics in the treatment of elderly patients when such treatment is detrimental to the patient but eases the burden placed on their carers.⁶⁰

The above considerations permit the conclusion to be drawn that a number of identifiable factors exist which, in situations of doubt, predispose towards a psychiatric committal; it should be noted that this is the converse of the presumption that applies in legal procedures under the criminal law which might lead to a committal to prison.

B.1.3: The term 'mental illness'

In that a psychiatric pre-diagnosis entails a finding that the subject was 'mentally ill', an examination of the latter term might help clarify the concept of pre-diagnosis; a brief sketch of the usage of the term in law is discussed in B.1.3.1; in psychiatry, in B.1.3.2 and in philosophy, in B.1.3.3.

B.1.3.1: Usage in law

To one of the psychiatrists in the Amy case: "*her habit of speaking tangentially was evidence of mental illness.*" He noted that:

Mental disorder is, in fact, very poorly defined in the various mental health acts, and this omission is quite deliberate. The physician need not establish an "identifiable psychiatric illness" as a requirement for involuntary committal.⁶¹

Hoggett (1990), in her textbook on English mental health law, states that the term 'mental illness' lacks legislative definition and she quotes from the only authoritative judicial interpretation:

... the words are ordinary words of the English language. They have no particular medical significance ... [they] should be construed in the way that ordinary sensible people would construe them.⁶²

Hoggett disdainfully comments:

It is impossible not to think of this as the '*man-must-be-mad*' test. It simply adds fuel to the fire of those who accuse the mental hygiene laws of being a

... physicians' perceptions of parental expectations for antimicrobials was the only significant predictor of prescribing when a viral diagnosis was assigned ... when physicians thought the parent wanted an antimicrobial, they prescribed them 62% of the time *versus* 7% of the time when they did not think the parent wanted antimicrobials ... [p.714-5]

... In one qualitative study, many physicians expressed concern that in the current competitive medical marketplace, failing to meet patient expectations could lead to dissatisfaction with care and loss of business. [p.716]

⁶⁰ Despite warnings from the UK Committee on Safety of Medicines against the practice, a survey found that some doctors prescribed anti-psychotic drugs to 90% of their elderly dementia patients. A spokesman for NICE commented that such practices were an "... *awful indictment.* ... *I think the doctors should be disciplined.*" [See also Chapter 5]

BBC (2008). 'File on 4: Doctors 'ignoring drugs warning' *BBC Radio 4*. 17 June. [online], available: http://news.bbc.co.uk/2/hi/programmes/file_on_4/7457132.stm [accessed: 27 June 2008].

⁶¹ See Appendix C.

⁶² *W. v L.* [1974] Q.B. 711.

sophisticated machine for the suppression of the unusual, eccentric or inconvenient behaviour.⁶³

The position in Irish law is little better and although the *Mental Health Act* (2001) does attempt a definition,⁶⁴ O’Neill (2005) in her textbook on Irish mental health law, dismisses it as “*circular*”.⁶⁵

B.1.3.2: Usage in psychiatry

The definition of ‘mental disorder’⁶⁶ adopted by the *DSM-IV* (2000)⁶⁷ is singularly unenlightening: a consideration of the near impossibility of establishing that any given individual subject does not have *any* mental disorder (*i.e.* is not ‘mentally ill’) is sufficient to make manifest its defects. Indeed one might conclude that it is the dearth of discussion of the concept of mental illness (as distinct from discussion of the various diagnostic categories) within psychiatry that is enlightening; Niall McLaren, in a trenchant rejoinder to Pies (2010)⁶⁸ has commented that the very absence of an adequate concept of mental illness, had the consequence that:

Psychiatry is most definitely NOT a science. It fails the first requirement of any field claiming to be scientific, an articulated model of the subject matter. Accordingly, to qualify as science, psychiatry would need a model of mental disorder, which it doesn't have. All talk of "evidence" amounts to naught until the evidence is seen to be *about something*.⁶⁹

Wiggins & Schwartz’s (1999) observation that US psychiatry lacks an adequate conception of mental health other than social conformity has been noted earlier;⁷⁰ and – in that ‘mental illness’ is the precise complement of ‘mental health’ – this implies that an adequate conception of the former is also lacking.⁷¹

⁶³ *Op. cit.*, p.48.

⁶⁴ *Op. cit.*, Section 3(2):

...“mental illness” means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment

⁶⁵ *Op. cit.*, p.104.

⁶⁶ The term ‘mental illness’ is the generic term for ‘mental disorder, *i.e.* X is mentally ill if, and only if, X has a mental disorder.

⁶⁷ *Op. cit.*, (p.xxxi):

... the term mental disorder unfortunately implies a distinction between “mental” disorders and “physical” disorders that is a reductionistic anachronism of mind/body dualism. ... Despite these caveats, the definition of mental disorder that was included in DSM-III and DSM-III-R is presented here because it is as useful as any other available definition ... In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (*e.g.*, a painful symptom) or disability ...

⁶⁸ Pies (2010) had argued that psychiatry is a science.

⁶⁹ McLaren (2011) [Emphasis in original]

⁷⁰ See Chapter 3.

⁷¹ A conclusion echoed by Culver & Gert (1982), p.20.

B.1.3.3: Usage in the philosophy of psychiatry

Brülde (2008) writing in *Philosophy, Psychiatry, & Psychology* begins by noting that: “It is now generally agreed that we have to rely on value judgements to distinguish mental disorders from other conditions, but it is not quite clear how.”; but, in conclusion, he adopts the criteria: “radical incomprehensibility”⁷² and “possibility of causing harm”.

Applying the proposed criteria to some of the cases (discussed earlier) where psychiatrists evinced no hesitation in ascribing ‘mental illness’, requires that we accept as examples of ‘radical incomprehensibility’:

- (i) an old woman, diagnosed with lymphoma, who decided to end her own life rather than pursue further medical treatment;⁷³
- (ii) a man who believes, but cannot prove, that his wife is unfaithful;⁷⁴
- (iii) a man who believed that civil servants were pursuing a school closure policy whilst concealing the fact of its illegality.⁷⁵

The converse situation – *i.e.* criminal cases where the conduct of the accused evinced a ‘radical incomprehensibility’ but where the possibility of the accused being mentally ill did not arise – are equally problematic. Consider the case of a mother who left her two-year-old son alone for the weekend whilst she socialised; the child had attempted to feed itself by looking through rubbish for food scraps. In convicting the mother the judge held that “It defies belief that any mother can treat her child in that way.”⁷⁶ Such behaviour clearly endangered her child and would seem to pass any test of radical incomprehensibility and dangerousness to others, yet the suggestion that the mother was mentally ill does not appear to have been canvassed before the court nor was it adverted to by the judge.⁷⁷

The fact that a proposed definition of mental illness does not accommodate such routine examples of the term brings to mind Austin’s admonition⁷⁸ in relation to philosophers who seek to define terms in a manner that is not consistent with their everyday use.

⁷² *Op. cit.*, p.99; citing Moore (1980): “we predicate ‘mentally ill’ of a person whenever we find his pattern of past behaviour unintelligible in some fundamental way.”

⁷³ *E.g.* the Amy case.

⁷⁴ *E.g.* the Bleheine case.

⁷⁵ *E.g.* the Juklerød case.

⁷⁶ Stratton, A. (2008). ‘Mother convicted of neglect after leaving toddler alone for weekend’. *The Guardian*. 5 June [online], available: <http://www.guardian.co.uk/uk/2008/jun/05/ukcrime.children> [accessed: 27 June 2008].

⁷⁷ The finding that the mother was mentally ill would have the consequence that she would not be held responsible for her acts.

⁷⁸ Austin (1962):

The definition of mental illness proposed by Brülde exemplifies the less than secure foundations on which some philosophical analysis of the term ‘mental illness’ is based.⁷⁹ What is required from philosophy of psychiatry is a set of rigorously defined criteria which can function as necessary and sufficient conditions so that a claim that a given subject is, or was, mentally ill can either be justified or refuted; nothing less is acceptable bearing in mind that a determination that a subject is mentally ill can have the profoundest effect on his life and liberty. Furthermore it is only marginally more onerous than the justifiability criterion that clinical psychiatrists seek to impose on a subject in diagnosing him as having a ‘delusional disorder’.⁸⁰

B.2: The reliability of psychiatric diagnosis

Spitzer & Fleiss (1974) reviewed the literature on diagnostic reliability and concluded that the level of reliability was “... *no better than fair for psychosis and schizophrenia and is poor for the remaining categories.*”⁸¹

Building on two, then current, developments, they proposed:

- the use of structured interview techniques; and
- the use of explicit criteria for the definition of individual mental disorders.

These proposals were embodied with increasing degrees of refinement, into the *DSM-III* and the *DSM-IV*.

Kutchins and Kirk have written extensively⁸² on these topics, and conclude that, in the intervening years and despite the rhetoric of science,⁸³ there is little evidence of any improvement in psychiatric diagnostic reliability:

Twenty years after the reliability problem became the central scientific focus of DSM, there is still not a single major study showing that DSM (any version) is routinely used with high reliability by regular mental health clinicians. Nor is there any credible evidence that any version of the manual has greatly increased its reliability beyond the previous version.⁸⁴

... but most words are in fact used in a particular way already, and this fact can't be just disregarded.” (For example, some meanings that have been assigned to 'know' and 'certain' have made it seem outrageous that we should use these terms as we actually do; but what this shows is that the meanings assigned by some philosophers are wrong.)
(p.62-3). [Emphasis in original].

⁷⁹ In this context, a remark by Wittgenstein (quoted earlier) is of interest: “*Madness need not be regarded as an illness. Why shouldn't it be seen as a sudden – more or less sudden – change of character?*” [Wittgenstein (1998), p.54].

⁸⁰ See Chapter 3.

⁸¹ *Op. cit.*, p.344.

⁸² E.g. Kirk & Kutchins (1992), Kirk & Kutchins (1994) and Kutchins & Kirk (1997).

⁸³ Kirk & Kutchins (1992) was entitled ‘*The Selling of DSM: The Rhetoric of Science in Psychiatry.*’

⁸⁴ Kutchins & Kirk (1997), p.55 and continues:

If the unreliability of diagnosis were widely recognized and if there were no scientific patina to DSM, the use of everyday behaviors as indicators of mental disorder would be more rigorously

Studies such as Hickling (1999) show the extent and seriousness of the problem posed by poor diagnostic reliability. Peter Hickling sought to determine whether the high rate of schizophrenia reported for African-Caribbeans living in the UK was due to misdiagnosis. To that end, the study compared diagnoses made by a black Jamaican psychiatrist with those made by white British psychiatrists and concluded:

Despite diagnosing schizophrenia in similar proportions of patients,⁸⁵ the Jamaican psychiatrist and British psychiatrists showed low levels of agreement on *which* patients had this illness. ... There was agreement on the diagnosis for 16 (55%) of these patients, and disagreement on the diagnosis for the other 13 (45%).⁸⁶

Drawing on Spitzer & Fleiss's comment that "*There is no guarantee that a reliable system is valid, but assuredly an unreliable system must be invalid.*"⁸⁷

It can be concluded that low levels of diagnostic reliability still existing under the DSM-IV necessarily imply the existence of high levels of psychiatric misdiagnosis.

B.3: The validity of psychiatric diagnosis

In non-psychiatric medicine, the validity of individual diagnostic categories has sometimes been questioned: Gulf War syndrome⁸⁸ and chronic fatigue syndrome are modern examples; the uncovering of a biological substratum or marker (which is present when the condition is present, absent when it is absent and which is indicative of a biological 'defect') is often sufficient to resolve such questions. Although some schools of modern psychiatry are replete with hypotheses concerning the biological underpinnings of various psychiatric conditions, to date these remain only hypotheses in that no biological indicator or test has been found which is diagnostic of a mental disorder;⁸⁹ thus problems concerning the validity of psychiatric diagnostic categories cannot be resolved by the methods used to resolve such questions in general medicine.

questioned by the public. The illusion that psychiatrists are in agreement when making diagnoses creates the appearance of a united professional consensus. In fact, there is considerable professional confusion.

⁸⁵ Raising the possibility that expected prevalence rates governed the choice of diagnostic criteria. [See *infra*]

⁸⁶ *Op. cit.*, p 284. [Emphasis in original]. See *infra* for a further discussion of the results.

⁸⁷ Spitzer & Fleiss (1974), p.341.

⁸⁸ See Gever, J. (2008). 'Panel Confirms Gulf War Syndrome Is Real and Causes Are Definable'.

MedPage Today [online], available:

<http://www.medpagetoday.com/PublicHealthPolicy/MilitaryMedicine/11814> [accessed: 20 November 2008].

⁸⁹ See, for example, First & Zimmerman (2006) (*supra*):

Many biological psychiatrists have argued for a crude form of biological reductionism in which it is assumed that brain abnormalities reflect aetiological processes that are unconnected to the social environment. However, this assumption is plainly false, because, as we have also seen, brain abnormalities alone provide few clues about aetiology.

Also Rego (2007), p.9:

Determinations as to the validity of diagnostic categories in general medicine – though important in determining, for example, rights as to legal compensation and insurance reimbursement for treatment – pale into insignificance in comparison with similar questions in psychiatry in that a determination that a particular psychiatric diagnostic category is valid, may be sufficient to ground a coercive psychiatric intervention.⁹⁰ Furthermore it is a consequence of a finding that an individual is ‘mentally ill’ (a necessary consequence of him being diagnosed as having a valid psychiatric illness) that his responsibility for acts referable to the illness is diminished if not wholly removed;⁹¹ for example, the proposal that ‘racism’ be categorised as a psychiatric illness in the draft *DSM-V*⁹² carries the implication that a subject diagnosed with such a condition, is not fully responsible for his acts.

In the history of psychiatry there are many examples of psychiatric diagnostic categories that are now regarded as little more than curiosities: ‘*drapetomania*’, (a slave’s excessive wish for freedom),⁹³ ‘*fugue*’ (an inordinate desire to travel)⁹⁴ are two such; these categories could be described as no longer having validity in that, their diagnostic criteria – though perhaps well defined and hence capable of being diagnosed reliably – are no longer considered to be capable⁹⁵ of constituting an illness; the removal⁹⁶ of homosexuality from the list of psychiatric diagnoses (*supra*) provides a more recent example.

It is difficult to intuit any underlying principles from such disparate examples and, viewed in the abstract, the concept of psychiatric diagnostic validity is considered to be

I do many second and third opinions and am shocked by the way the biomedical model has hijacked clinical thinking. The mountains of biological data about psychiatric illness may help treat such problems – they have in fact done so only in very limited ways so far – but they certainly do not explain much of what is happening to someone apart from saying it is biological.

⁹⁰ Thus, prior to the vote of the APA (*supra*) on 14th December 1974, homosexuality was a valid diagnostic category and thus an individual homosexual subject was deemed ‘mentally ill’ – and thus susceptible to involuntary psychiatric treatment – yet on the day after the vote that same individual was not mentally ill despite his mental condition being unchanged. Such an instant ‘cure’ by fiat appears to have little to do with science or the scientific method. [See *Time* (1974)].

⁹¹ See *infra*.

⁹² See, for example, Bell (2005) and *infra*.

⁹³ See, for example, Szasz (1971).

⁹⁴ See, for example, Hacking (1999).

⁹⁵ This implicitly raises the question of the ‘ownership’ of the concept ‘mental illness’ *i.e.* who has the right to define a particular set of criteria as constituting a ‘mental illness’. [See *infra*]

⁹⁶ The resolution passed in 1973 by the American Psychiatric Association was quite nuanced:
... by itself, homosexuality does not meet the criteria for being a psychiatric disorder. We will no longer insist on a label of sickness for individuals who insist that they are well and demonstrate no generalized impairment in social effectiveness.

See Grimes, W. (2011). ‘Alfred Freedman, a Leader in Psychiatry, Dies at 94.’ *The New York Times*. 20 April.

a topic fraught with difficulty.⁹⁷ However an insight into the problem – sufficient for a discussion of psychiatric misdiagnosis – is provided by a brief discussion of some examples concerning the inclusion of particular diagnostic categories in the *DSM-III-R* (1987) [B.3.1] and in *DSM-V* [draft] (2010)⁹⁸ [B.3.2].

Some general comments are included in B.3.3.

B.3.1: Assessment of proposals for inclusion in the *DSM-III-R*

Karen Ritchie describes a meeting between some ‘feminist’ psychiatrists⁹⁹ and a sub-committee of the APA, concerning some proposed diagnostic categories.

The committee began its deliberation in the presence of the women psychiatrists and Ritchie (1989) provides eloquent testimony to the processes sometimes involved in the conferring, or withholding, of psychiatric diagnostic validity:

The feminists were appalled that ... criteria, and even whole diagnoses, were created or dispensed within a session that involved a small group seated around a computer terminal. ... One of the invited participants reports that “*Each shouted out ideas for criteria coming from their own experience ... If the behavior was observable in patients, then a nosology category could be created.*” However, “*one criterion was dropped because a workgroup member piped up with ‘I do that sometimes.’*”¹⁰⁰

The diagnostic categories under review were: ‘*premenstrual syndrome*’ [PMS]; ‘*paraphilic rapism*’ and ‘*masochistic personality disorder*’.

Premenstrual syndrome

The discussion centred on the meaning of ‘disease’: it had been suggested that because 40-60% of women experienced PMS it was ‘normal’ and hence not a disease; ‘tooth decay’ – being a disease suffered by, possibly, the majority of individuals – was offered as a counterexample to this line of reasoning.

It was also argued that if PMS was to be categorised as a disorder, then: “... [*it*] would only perpetuate stereotypes about the emotional instability of women.”¹⁰¹ and that furthermore: “... [*it*] might be more appropriately a gynecological disorder than a psychiatric one, given the presumed hormonal cause.”¹⁰²

⁹⁷ Kendell & Jablensky (2003), p.5: “*However, the meaning of validity in the context of diagnosis has never been adequately clarified.*”

See also, Robins & Barrett (1989).

⁹⁸ The *DSM-V* is due to be released in 2013.

⁹⁹ The proposals were controversial in that they possibly offended against feminist sensibilities.

¹⁰⁰ *Op. cit.*, p.698. [References omitted].

¹⁰¹ Ritchie (1989), p.695.

¹⁰² *Ibid.*

In the event, PMS was renamed “*late luteal phase disorder*”¹⁰³ and included in an appendix amongst disorders needing further study.

Paraphilic rapism

It was noted that to categorise compulsive rapists as having a mental disorder:

... would allow a rapist to plead insanity and thereby avoid a prison term. The committee found this argument persuasive enough that the diagnostic category was dropped.”¹⁰⁴

Masochistic personality disorder

As reported by Ritchie (1989):

One of the feminists reported that the committee offered a compromise – “*if we backed off on masochism, they would create a sadistic disorder to cover wife beaters*”. ... The offer of adding a new diagnosis of sadistic disorder, apparently created on the spot, only reinforced the opinion that diagnoses were being made without adequate scientific backing.¹⁰⁵

B.3.2: The draft *DSM-V*

Not only have some of the diagnostic categories proposed for inclusion in the *DSM-V* come under sustained criticism but so has the editorial process itself. The list of proposed diagnoses is extensive and controversial and includes, *inter alia*: ‘*compulsive shopping*’; ‘*apathy*’; ‘*post-traumatic embitterment disorder*’; ‘*hypersexuality*’; ‘*racism*’; ‘*binge eating*’; ‘*psychosis risk syndrome*’; ‘*temper dysfunctional disorder with dysphoria*’; ‘*chronic complaint disorder*’; ‘*gambling disorder*’.¹⁰⁶

The critics of the draft *DSM-V* are notable not only for the vehemence of their criticism but for their eminence, the most renowned being Robert Spitzer¹⁰⁷ and Allen Frances¹⁰⁸ who in a joint letter to the APA, stated:

The suggested subthreshold and premorbid diagnoses ... could add tens of millions of newly diagnosed “patients” – the majority of whom would likely be false positives subjected to the needless side effects and expense of treatment. ... in its effort to increase diagnostic sensitivity, it has been insensitive to the great

¹⁰³ *Ibid.*, p.699.

¹⁰⁴ *Ibid.*, p.696.

¹⁰⁵ *Op. cit.*, p.698.

¹⁰⁶ A possible explanation of the apparent readiness of psychiatrists to create new diagnostic categories, lies in the fact that a psychiatrist will not be reimbursed for the treatment of a patient in the absence of a diagnosis made in accordance with the DSM: see, for example, Caplan & Cosgrove (2004):

In addition to growing in size, this manual has become increasingly influential, due to the fact that third-party reimbursement now usually requires that patients receive a DSM diagnosis. (p.xxi)

A list of all such diagnoses with their appropriate ‘billing codes’ is provided in *DSM-IV* (2000), Appendix F.

¹⁰⁷ Spitzer was an editor of both the *DSM-III* and *DSM-IV*.

¹⁰⁸ Frances was the chair of the *DSM-IV* Task Force.

risks of false positives, of medicalizing normality, and of trivializing the whole concept of psychiatric diagnosis.¹⁰⁹

They also noted that the APA might well be accused of: "... *a conflict of interest in fashioning DSM-V to create new patients for psychiatrists and new customers for the pharmaceutical companies.*" The APA responded in kind.¹¹⁰

Frances & Spitzer (2009) also criticised the "*rigid fortress mentality*" adopted by the APA which resulted in a "*closed and secretive DSM-V process*"¹¹¹ which ensured that the deliberations leading to the proposal of new diagnostic categories were concealed. Another eminent critic Edward Shorter,¹¹² who is also critical of the state of modern psychiatry, argues that even a cursory reading of the *DSM-V*:

... is to see the discipline's floundering writ large. Psychiatry seems to have lost its way in a forest of poorly verified diagnoses and ineffectual medications. Patients who seek psychiatric help today for mood disorders stand a good chance of being diagnosed with a disease that doesn't exist and treated with a medication little more effective than a placebo.¹¹³

Frances (2010) is equally scathing:

DSM5 would create tens of millions of newly misidentified false positive "patients," thus greatly exacerbating the problems caused already by an overly inclusive DSM4. There would be massive overtreatment with medications that are unnecessary, expensive, and often quite harmful. DSM5 appears to be promoting what we have most feared – the inclusion of many normal variants under the rubric of mental illness, with the result that the core concept of "mental disorder" is greatly undermined.¹¹⁴

Of the proposed diagnoses, '*psychosis risk syndrome*' and '*hypersexual disorder*' have been elicited particularly strong criticism:

¹⁰⁹ Frances & Spitzer (2009).

¹¹⁰ Frances (2009a):

I had intended not to reply to the silly suggestion made by the APA leadership that I wrote my critique of the DSM-V process out of financial motivations:

Both Dr. Frances and Dr. Spitzer have more than a personal "pride of authorship" interest in preserving the DSM-IV and its related case book and study products. Both continue to receive royalties on DSM-IV associated products.

¹¹¹ *Ibid.*

¹¹² Edward Shorter is Professor of the History of Medicine and Psychiatry in the Faculty of Medicine of the University of Toronto.

¹¹³ Shorter, E. (2010). 'Why Psychiatry Needs Therapy.' *The Wall Street Journal*. 27 February. [online], available: http://online.wsj.com/article/SB10001424052748704188104575083700227601116.html?mod=WSJ_latesheadlines#printMode [accessed: 24 March 2010].

¹¹⁴ *Op. cit.*

Psychosis risk syndrome

Spitzer, in criticising this diagnosis, stated: "*There will be adolescents who are a little odd and have funny ideas, and this will label them as pre-psychotic, ...*";¹¹⁵ a criticism which has been echoed by Michael First:¹¹⁶

I completely understand the idea of trying to catch something early, but there's a huge potential that many unusual, semi-deviant, creative kids could fall under this umbrella and carry this label for the rest of their lives.¹¹⁷

Frances (2010) has been equally trenchant:

The Psychosis Risk Syndrome is certainly the most worrisome of all the suggestions made for DSM5. The false positive rate would be alarming – 70% to 75% in the most careful studies and likely to be much higher once the diagnosis is official, in general use, and becomes a target for drug companies. Hundreds of thousands of teenagers and young adults ... would receive the unnecessary prescription of atypical antipsychotic drugs.¹¹⁸

Hypersexual disorder¹¹⁹

In the present context, the proposed disorder is of particular interest in that it highlights three issues, which have been adverted to earlier, and which are of more general importance:¹²⁰

- the relationship between (statistical) normalcy and illness;
- the 'ownership' of the concept of mental illness;
- the use of 'illness' as a mechanism for the evasion of responsibility.

The first two are exhibited in the following scenario:

What will be more common in my experience is one person is saying, '*You're a sex addict,*' and the other person is saying, '*You're undersexed.*' There's a power struggle going on in the relationship and it's being played out in the marital bed. Who has the right to determine which one of them is pathological?¹²¹

The evasion of personal responsibility is exemplified by the adulterer who on discovery, claims to be suffering from sexual addiction.¹²²

¹¹⁵ Stein, R. (2010). 'Revision to the bible of psychiatry, DSM, could introduce new mental disorders.' *The Washington Post*. 10 February.

¹¹⁶ Michael First is Professor of Psychiatry at Columbia University and was an editor of the *DSM-IV*.

¹¹⁷ Carey, B. (2010). 'Revising Book on Disorders of the Mind.' *The New York Times*. 10 February.

¹¹⁸ *Op. cit.*

¹¹⁹ The first two editions of the DSM listed '*nymphomania*' (and its male version '*satyriasis*') though according to Dr. Kleinplatz (of the Faculty of Medicine at the University of Ottawa) both were removed from the *DSM-III* because "*after the sexual revolution, too much sex was no longer seen as pathological.*" [online], available: <http://m.theglobeandmail.com/life/family-and-relationships/too-much-sex-doctors-want-to-make-the-diagnosis-official/article1473474/?service=mobile&page=0#article> [accessed: 24 March 2010].

¹²⁰ These issues will be discussed in B.3.3 (*infra*).

¹²¹ Kleinplatz (*supra*).

¹²² *Ibid.*

B.3.3: Some general comments on validity

Three issues will be discussed: the ‘ownership’ of the concept of mental illness [B.3.3.1]; the links between (statistical) normalcy and the definition of mental illness [B.3.3.2] and between validity and misdiagnosis [B.3.3.3].

B.3.3.1: The validator of the concept ‘mental illness’¹²³

At first glance the answer to question: *Who has the right to specify that a condition satisfying a particular set of criteria, is a ‘mental illness’?* would appear to be obvious: ‘psychiatrists’, much as the question: *Who has the right to specify the criteria that define whether a particular astronomical object, is a ‘planet’?* elicits the answer: ‘astronomers’; but such an answer would be an oversimplification. The psychiatric profession clearly has the right to specify the criteria for the use of terms which lie solely within its own professional compass¹²⁴ but it has not the right to attempt a redefinition of words which already have an established meaning in common parlance¹²⁵ and whose ascription or attempted redefinition may have serious consequences outside the narrow field of professional psychiatry . Thus, taking as example the Juklerød case,¹²⁶ psychiatry certainly has the right to define the criteria for *paranoia querulans* but it does not necessarily have the right to proclaim *paranoia querulans* to be a ‘mental illness’¹²⁷ because such a declaration can have profound repercussions within the wider society both as to involuntary detention and treatment¹²⁸ and the removal of responsibility for one’s actions.

If the point being argued appears to be unduly contentious¹²⁹ then the examples (in US psychiatry) of ‘homosexuality’ and (in Soviet psychiatry), of ‘sluggish schizophrenia’¹³⁰

¹²³ See Foucault (2004) (*supra*): “What is it to be mad? Who decides? ... In the name of what?”

¹²⁴ I.e. ‘terms of art’.

¹²⁵ See Austin’s (1962) admonition (*supra*).

¹²⁶ Appendix G.

¹²⁷ See Hoggett (1990) (*supra*), who cites as the only authoritative statement in English law on the meaning of ‘mental illness’:

... the words are ordinary words of the English language. They have no particular medical significance ... [they] should be construed in the way that ordinary sensible people would construe them.

¹²⁸ Such as occurred in the Juklerød case.

¹²⁹ A possible analogy might be drawn with the terms ‘art’ and ‘artist’: Is it only academic artists and art critics, that can decree whether a particular work constitutes art? See, for example, Clouston (2009):

Does breaking a window count as art? Yes, murmured the 50 or so artniks who recently crowded into a former Edinburgh ambulance garage to view a film of sculptor Kevin Harman doing just that. No, insisted Kate Gray, director of the Collective Gallery in Cockburn Street, whose window it was. The courts are on Gray’s side. Yesterday Harman, a prize-winning graduate of Edinburgh College of Art, was fined £200 for breaching the peace on 23 November, when he smashed a metal scaffolding pole through one of the gallery’s windows.

Clouston, E. (2009). ‘Glass act: student fined for smashing gallery window and calling it art.’ *The Guardian*. 18 December.

¹³⁰ See *infra*.

should be borne in mind; in both cases it was the power of an informed public opinion that, in the face of resistance from the psychiatric profession,¹³¹ reasserted its dominance.

Thus the conclusion can be drawn that assessments of the validity of a particular psychiatric diagnostic category – in that they necessarily entail ascriptions of mental illness¹³² to those satisfying the diagnostic criteria – are not solely the prerogative of the psychiatric profession but also require at least the tacit acquiescence of informed public opinion. In short, though psychiatrists are the normal custodians of the concept of psychiatric validity, this is by way of an implicit delegation from the wider public.¹³³ This conclusion implies that a strong consensus of informed public opinion is of itself sufficient to undermine the validity of a particular psychiatric diagnostic category irrespective of the opinion of professional psychiatry. In particular, to adjudge that, for example, Juklerød was the subject of a psychiatric misdiagnosis, it is not necessary to find some psychiatric consensus, nor some legal judgement; the court of an informed public opinion is, of itself, sufficient.¹³⁴

B.3.3.2: (Statistical) normalcy and mental illness

The problems that arise when ‘illness’ and ‘normalcy’ are regarded as complementary concepts and ‘normalcy’ is interpreted in terms of ‘statistical normalcy’ have been alluded to earlier;¹³⁵ a similar problematic analysis is in play when prevalence rates of competing diagnostic criteria are canvassed in ‘field trials’ to ensure that:

- a diagnosis of psychiatric illness does not include an unduly large segment of the population;¹³⁶
- the diagnostic criteria are sufficiently precise as not to result in an ‘unacceptable level’ of false positives. [See *infra*]

¹³¹ The initial reports of Soviet psychiatric abuse were met with “*near-complacence*” by the World Psychiatric Association and it was only by virtue of considerable external political pressure that the association investigated such practices. [Bloch & Reddaway (1984), p.44.]

The international psychiatric community had not only been reluctant to criticize their Soviet colleagues but, prior to being pressured to change their view, had been openly admiring of the practice of psychiatry in the USSR, Lebensohn (1968) for example, had stated: “*The experienced members of this important mission have carefully scrutinised many facets of Soviet psychiatry and have emerged with a remarkably favorable estimate of its effectiveness.*”

¹³² Comparative linguistic and philosophical studies of both lay and psychiatric usage of the term ‘mental illness’ would be of interest; see Nordt (2006) [discussed in Chapter 7] in this regard.

¹³³ The danger of a too ready bending to the public will should also be borne in mind. Maden (2007), in his discussion of psychiatric assessments of dangerousness, provides a cautionary example against a professional overwillingness to yield to political pressure. [See *infra* and Appendix F]

¹³⁴ The verdict of public opinion appears to be that Juklerød was indeed subjected to a wrongful diagnosis of mental illness. [See Appendix G.]

¹³⁵ See Chapter 3.

¹³⁶ See, for example, Frances (2010).

In relation to the first point: the use of prevalence rates as a *determinant* of the validity of a proposed ‘psychiatric illness’¹³⁷ appear to be an instance of the ‘tail wagging the dog’, whose only justification could lie in an *a priori* adoption of a principle to the effect that mental illness is *necessarily* a minority phenomenon; the existence of such a principle has been gently mocked in the observation: “‘One in four’ is the pi of the therapeutic society.”¹³⁸

B.3.3.3: Validity and misdiagnosis

Some commentators maintain that the *DSM-IV* diagnostic categories though, of some use, have little validity in that they do not ‘*cleave nature at the joints*’; Kendell and Jablensky (2003), for example, state:

Despite historical and recent assumptions to the contrary, there is little evidence that most currently recognized mental disorders are separated by natural boundaries. Researchers are increasingly assuming that variation in symptoms is continuous and are therefore questioning the validity of contemporary classifications.¹³⁹

Other critics are more extreme in that they maintain that the DSM project itself is deeply flawed: an editorial in the *American Journal of Psychiatry*, for example, states:

The DSM diagnosis has almost become a thing in itself – a certainty of “concrete” dimensions. ... the main goal of clinical practice. ... has even assumed the aura of allowing psychiatry to keep pace with the rest of medicine as a “technological triumph” but our current diagnostic process and zeal may also be ruining the essence of psychiatry.

... [it] gives the image of precision and exactness. In fact, many have come to believe that we are dealing with clear and discrete disorders rather than arbitrary symptom clusters. All of this apparent precision overlooks the fact that as yet, we have no identified etiological agents for psychiatric disorders. ... We are not looking at or studying the patient's phenomenology anymore but are looking for the symptoms needed to make the diagnosis.¹⁴⁰

Yet other critics argue that the root of the problems that beset psychiatry lies in its futile attempts to mimic the scientific methods and exactitude which are characteristic of general medicine; a strategy which ensures the “*loss of the personal*”¹⁴¹ from psychiatric discourse. Analyses such as Flanagan (2007), suggest that the very act of forcing the richness of human experience into categories amenable to a diagnostic

¹³⁷ See Ritchie (1989) *supra* and the objection that since PMT was suffered by the majority of women it could not be a ‘mental illness’.

See also Frances (2010):

Minor Neurocognitive Disorder is defined by nonspecific symptoms of reduced cognitive performance that are very common ... but getting a meaningful reference point is impossible in most instances and the threshold has been set to include a whopping 13.5% of the population.

¹³⁸ Fitzpatrick (2003).

¹³⁹ *Op. cit.*, p 4.

¹⁴⁰ Tucker (1998).

¹⁴¹ Wiggins & Schwartz (1999).

taxonomy such as envisaged by the DSM, causes a deformation so gross as to invalidate any structure built upon such a taxonomy. Flanagan (2007) concludes with a plea that the issue of validity be urgently addressed; indeed the task force charged with undertaking the preliminary research for the *DSM-V* called for validity to be the focus of the revision process.¹⁴²

Such authoritative calls from within the psychiatric profession provide eloquent testimony to the seriousness of the problems that exist in the *DSM-IV* concerning psychiatric diagnostic validity. Furthermore, the earlier discussion¹⁴³ on the draft *DSM-V* shows that not only have any hopes that it may resolve the problem of psychiatric validity been dashed, but the problem appears to have been exacerbated.

Diagnostic categories which lack validity necessarily entail the occurrence of psychiatric misdiagnosis; moreover a misdiagnosis of an especially serious kind¹⁴⁴ in that not only is a subject assigned to an invalid diagnostic category but he may well be erroneously labelled as ‘mentally ill’.

The theoretical occurrence of misdiagnosis under such as the draft *DSM-V* is not restricted to diagnostic categories which lack validity but is structurally intrinsic to the DSM process under the guise of ‘false positives’; the term ‘false positive’ – and the term ‘overdiagnosis’¹⁴⁵ – being nothing other than euphemisms for ‘psychiatric misdiagnosis’.¹⁴⁶

Frances (2009b) adverted to the use of field trials to determine rates of ‘false positives’ and he was highly critical of the use of such trials in the absence of unambiguous, precisely drawn, diagnostic criteria.¹⁴⁷ In relation to the *DSM-IV* – which he implied used considerably greater rigour in its specification of diagnostic criteria than the *DSM-*

¹⁴² Thornton (2007a), p.12:

... whilst great advances were made in *DSM III* and *IV* in increasing the reliability of psychiatric diagnosis, this may have been at a cost of its validity. Thus the task force carrying preliminary research for the next revision – *DSM V* – have called for validity to be placed at the centre of the revision process.

¹⁴³ B.3.2 (*supra*).

¹⁴⁴ See Section C (*infra*).

¹⁴⁵ See, for example, Zimmerman (2008) who asks: “*Is bipolar disorder overdiagnosed?*”

¹⁴⁶ The euphemistic nature of the terminology is readily apparent if one considers other procedures which may also result in deprivation of liberty: *e.g.* a wrongful conviction termed an ‘overconviction’.

¹⁴⁷ See Frances (2010):

It will likely be argued by the DSM5 leadership that I am unduly and prematurely alarmist, ... and that any problematic suggestions will eventually be weeded out in the field trials. This is putting the cart (*i.e.* field testing) before the horse (*i.e.* having usable criteria sets to test) and continues to miss the point that DSM5 has been and remains in serious trouble. ...

Field trials are arduous and expensive and make sense only for testing the precise wording of criteria sets that have a real chance of making it into the manual – not for the many poorly written and far out suggestions that have just been posted.

V [draft] – he suggested that the *clinical* ‘false positive rate’ occurring in diagnoses was in excess of that found in field tests¹⁴⁸ and that consequently¹⁴⁹ the *clinical* ‘false positive rate’ of *DSM-V* if the draft is adopted could be extremely high.¹⁵⁰

Frances (2010) attempted to answer why the risk of such misdiagnosis attracts such little attention:

How can such smart and scrupulous people make so many bad suggestions? It has been my consistent experience ... that each Work Group always has a strong (and seemingly irresistible) bias for expanding the boundaries of the disorders in its section. This expectable Work Group diagnostic imperialism must always be recognized and resisted. Experts understandably place a high value on reducing false negatives for their favorite disorders ... Unfortunately, Work Group members usually have a correspondingly huge blind spot – missing the fact that every effort to reduce the rate of false negatives must inevitably raise the rate of false positives (often dramatically and with dire consequences).

The acknowledgement of acceptable levels of ‘false positives’ or ‘overdiagnosis’ in DSM field trials in addition to the recognition that these levels are likely to be exceeded in clinical practice, implies a formal acceptance of the occurrence of not inconsequential levels of psychiatric misdiagnosis.

B.4: Psychiatry as science

Michel Foucault is scathing in his critique of psychiatry’s claim to being a science calling it laughable,¹⁵¹ “*Ubu-esque*”,¹⁵² “*grotesque*”¹⁵³ and compares the psychiatrist giving evidence in a criminal trial, to a buffoon:

He can exercise the terrible power he is asked to take on – which in the end is to determine, or to play a large part in determining, an individual's punishment – only through a childish discourse that disqualifies him as scientist at the very moment he is appealed to as a scientist, ... The scientist, who is sheltered, protected, and even regarded as sacred by the entire institution and sword of justice, speaks the language of children and the language of fear ... Buffoonery and the function of expert are one and the same: it is as a functionary that the expert is really a clown.¹⁵⁴

¹⁴⁸ Frances (2009b): “*A lesson from DSM-IV is that field testing cannot always predict the rates of mental disorders once a diagnostic system enters general use.*” (p.1322).

¹⁴⁹ Frances (2010) (*supra*): “... *DSM5 would create tens of millions of newly misidentified false positive patients,*” thus greatly exacerbating the problems caused already by an overly inclusive *DSM4*.”

¹⁵⁰ Frances (2010) (*supra*): “... *alarming - 70% to 75% ...*”

¹⁵¹ Foucault (2003), p.6: “*And discourses of truth that provoke laughter and have the institutional power to kill.*”

¹⁵² *Ibid.*, p.14: “... *justice has installed a discourse that is Ubu's discourse; it gives voice to Ubu science ...The theory, therefore, of the psychiatric-penal Ubu.*”

¹⁵³ *Ibid.*, p.11:

However, these statements [GR: *i.e.* psychiatric expert evidence] also have the curious property of being foreign to all, even the most elementary, rules for the formation of scientific discourse, as well as being foreign to the rules of law and of being, in the strict sense, grotesque.

¹⁵⁴ *Ibid.*, p.36.

Using more temperate language, Drury (1996) (a psychiatrist who had been a pupil of Wittgenstein) also scorned psychiatry's pretensions to scientific status:

... we must admit that the vocabulary of psychiatry today is only too comparable with what Lavoisier has to say about the nomenclature of chemistry in its childhood. We have indeed a *nomenclature*, but we have no *system of naming*. ... Let us beware lest from this unsystematic nomenclature suppositions are drawn, which then become presumptions and only too easily pass over into established truths.¹⁵⁵

Hence it is something of a surprise to find Jennifer Hansen, a member of the Executive Council of the *Association for the Advancement of Philosophy and Psychiatry* (and a professor of philosophy), arguing that the achievement of a detailed and comprehensive diagnostic compendium such as the *DSM* was definitive proof of psychiatry's place in "normal science":

The *DSM-III* was the rebirth of psychiatry in the biomedical paradigm; it gave psychiatry "*street cred*" with other medical specialties and it initiated real research agendas.¹⁵⁶

Writing in reply G. Scott Waterman¹⁵⁷ takes a more jaundiced view¹⁵⁸ – a perspective endorsed by others within academic psychiatry:

... it is time for the arbitrary, legalistic symptom checklists of the *DSM* to go ... [it] is a laughingstock for the other medical specialties; ... is so intellectually incoherent as to raise eyebrows among the well-educated, critical thinkers in our own psychotherapy clientele; ...¹⁵⁹

A more recent contributor to the debate sought to invoke a definition of science proffered by the British Science Council in support of the contention that psychiatry is a science;¹⁶⁰ though a riposte by McLaren (2011) is scornful of the suggested definition: "*Pyramidology follows 'a systematic methodology based on evidence' but it is not thereby scientific.*" and suggests that psychiatry is mere 'scientism'.¹⁶¹

¹⁵⁵ Drury (1996), p.1-3. [Emphasis in original]

Towards the end of *Philosophical Investigations*, Wittgenstein remarks:

The confusion and barrenness of psychology is not to be explained by calling it a young science; its state is not comparable with that of physics, for instance, in its beginning. ... For in psychology there are experimental methods and conceptual confusion. ... The existence of experimental methods makes us think we have means of solving problems which trouble us; though problems and methods pass one another by. (p.30)

¹⁵⁶ Hansen (2007), p.2.; see the Introduction for a more complete quotation.

¹⁵⁷ G. Scott Waterman is Professor of Psychiatry at the University of Vermont.

¹⁵⁸ Waterman (2007), p.13: "*She ... asserts that our byzantine compendium of diagnoses has earned us the respect of other medical specialties, which would be undeserved if it were true.*"

¹⁵⁹ Genova (2003).

¹⁶⁰ Pies (2010):

Recently, the British Science Council spent a full year developing a definition of "science." Their work-product is succinct and yet radically insightful: "*Science is the pursuit of knowledge and understanding of the natural and social world following a systematic methodology based on evidence.*"

¹⁶¹ McLaren (2011); he continues:

Hansen's argument rested on the fact that with the advent of the *DSM-IV*, psychiatry had developed a comprehensive taxonomy, or nosology, of diagnostic categories each with an explicit 'check-list' of criteria for its ascription. However the development of such a taxonomy in a particular discipline, whilst it might conceivably, be a necessary condition for the discipline being regarded as a science, is assuredly not a sufficient condition.¹⁶²

A taxonomy is only a prelude to scientific endeavour; if the system of classification chosen is apposite then it can facilitate, or even suggest, pathways to be explored. This task of exploration is the beginning of the scientific project. When it is well underway, testable hypotheses can be generated and from such efforts a scientific theory may develop. But to begin this process, the choice of taxonomy must be fortuitous: it must – as the Periodic Table was to Chemistry – 'cleave nature at its joints'. Psychiatry is only at the beginning stage of choosing a taxonomy and it is by no means clear that in the *DSM*, it has made an apposite choice. Indeed the chairperson of the *DSM-IV* task force¹⁶³ has stated that:

... we are at the epicycle stage of psychiatry where astronomy was before Copernicus and biology before Darwin. Our inelegant and complex current descriptive system will undoubtedly be replaced by ... simpler, more elegant models.¹⁶⁴

The absence of any biological test or marker determinative of the presence of any mental illness has been adverted to earlier and should, in conjunction with the extremely informal procedures adopted by the *DSM-III* and *DSM-V* in relation to the creation of diagnostic categories,¹⁶⁵ be sufficient to dispel any suggestion that psychiatry could lay claim to being a science.¹⁶⁶ But perhaps the most telling criticism of the argument that

In the absence of a formal model of mental disorder, psychiatry's obsessive preoccupation with brain enzymes, statistics and genes is mere scientism, the inappropriate application of scientific methods and principles to questions with no empirical content.

¹⁶² E.g. the *Stanley Gibbons Stamp Catalogue* is an excellent taxonomical system but it has nothing to do with scientific endeavour.

Hansen appears to be one of those philosophers described by Papineau (2006) (*supra*) who see the role of philosophy as being that of buttressing the status quo whether this is manifested in 'common sense' or in professional consensus.

¹⁶³ Allen Frances (*supra*).

¹⁶⁴ Quoted in Kendell & Jablensky (2003).

See also Drury (1996) (*supra*); and also Tucker (1998) (*supra*): "In psychiatry, no matter how scientifically and rigidly we use scales to estimate the patient's pathological symptoms, we are still doing pattern recognition."

¹⁶⁵ *Supra*.

¹⁶⁶ This is not to deny that psychiatry – like other disciplines such as archaeology or history – whilst not a science may rely on technologies which are themselves scientific. An example of the confusion of these two issues is to be found in a letter to *The Irish Times* [16 November 2006] from the six eminent academic psychiatrists:

In implying that mental illness cannot be the subject of scientific methodology, he disparages the output of thousands of researchers working in psychiatric epidemiology, psychobiology, genetics,

psychiatry is a science is due to Fulford. Reich (*supra*) had argued that the abuses that had occurred in Soviet psychiatry were occasioned by its lack of scientific rigor. Fulford's riposte is one that goes to the heart of the philosophy of psychiatry and is to the effect that any project such as envisaged by Reich – *i.e.* to establish a rigorous scientific base for psychiatry of a richness sufficient to generate the psychiatric diagnostic categories – is doomed to failure; to Fulford, the language of psychiatry – and, in particular, psychiatric diagnostic practice – cannot be expressed by exclusively factual propositions but is irredeemably dependent on value judgements many of which are contentious.

The danger of abuse occurs when psychiatry seeks to portray itself as a purely scientific endeavour because this permits the values inherent in psychiatric diagnostic procedures not only to lie hidden and unexamined, but to be denied.

A re-examination of the Rosenhan experiment and the Juklerød and Blehein cases, will show how distant the practice of psychiatry is from the practice of a scientific discipline: how can the statement that Rosenhan had been mentally ill but his illness was now in remission, be falsified? How can the statement that Juklerød had *paranoia querulans* or that he suffered from a 'symptom-free mental illness' be challenged? If inability to justify a deeply held belief is taken as characteristic of a delusion, then how can Blehein's inability to justify his belief as to his wife's infidelity be a delusion whilst a psychiatrist who is unable to justify a belief on the efficacy of a particular treatment,¹⁶⁷ not be delusional?

The argument that psychiatry is a science can be viewed on one level as a claim to privilege: that being a science it is an esoteric discipline intelligible only to the initiated and hence only such initiates are in a position to adequately formulate a criticism of psychiatry. It was by asserting such a claim to scientific status, that psychiatry achieved market dominance over psychotherapy.¹⁶⁸

neuro-imaging, pharmacology *etc.* whose results are accepted by the wider scientific community and published in the most prestigious peer-reviewed journals.

¹⁶⁷ See Chapter 5.

¹⁶⁸ See, for example, the comments of the historian of psychiatry, Andrew Scull:

More swiftly and silently than the Cheshire cat, psychoanalytic hegemony vanished, leaving behind not a smile, ...

The US National Institute of Mental Health proclaimed the 1990s "the decade of the brain". simplistic biological reductionism increasingly ruled the psychiatric roost. Patients and their families learned to attribute mental illness to faulty brain biochemistry, defects of dopamine, or a shortage of serotonin. It was biobabble as deeply misleading and unscientific as the psychobabble it replaced, but as marketing copy it was priceless. [Scull (2010), p.1246-7]

See also Rissmiller & Rissmiller (2006).

But the belief that psychiatry is a science can also have ethical consequences. Whilst it is not a necessary consequence of perceiving psychiatry as a purely scientific discipline, a psychiatrist faced with what he perceives to be a mentally ill patient is tempted – whether for reasons of psychiatric hubris or an uncritical altruism – to ‘solve’ the problem that he perceives. He believes that, provided he acts in the ‘best interests’ of his patient then there is no room for any criticism of his interventions.¹⁶⁹

An anthropologist, Tanya Luhrmann¹⁷⁰, who spent a number of years observing psychiatrists in their clinical practice,¹⁷¹ is strongly critical – on ethical grounds – of such views. She sees the choice between two competing models of illness and treatment in psychiatry (the biomedical and the psychodynamic) as a choice between understanding patients “*only as the detritus of a broken brain*” or as “*engaged in the struggle to be decent, responsible people.*”¹⁷² The Manweiler case¹⁷³ – especially in relation to his psychiatrist’s unwillingness to engage in meaningful dialogue with Manweiler – exemplifies the former. It will be argued in Chapter 7 that the adoption of such a stance by a psychiatrist necessarily results in the diminution, if not the destruction, of a subject’s personhood.

Section C: ‘Misdiagnosis’: ambiguities and sources

The ambiguities surrounding the term ‘psychiatric misdiagnosis’ are discussed in *Subsection C.1*. Some of the roots of psychiatric misdiagnosis are also to be found in general medicine – *e.g.* diagnostic overconfidence¹⁷⁴ – others are particular to psychiatry and these will be discussed in *Subsection C.2*.

C.1: Disambiguation of the term ‘misdiagnosis’ in the context of psychiatric practice

C.1.1: Technical misdiagnosis

In general medicine, the meaning of the term ‘misdiagnosis’ is unambiguous: it refers to the assigning of a subject’s illness to an incorrect diagnostic category; a similar usage

¹⁶⁹ Hansen (2007) (*supra*): “... psychiatrists now believe that what they do is indeed above reproach. That is what it means to have become a “normal science, ...”.

¹⁷⁰ Tanya Luhrmann is Professor of Anthropology at Stanford University.

¹⁷¹ Luhrmann (2000).

¹⁷² Rieder (2001), p.985.

¹⁷³ See Appendix H.

¹⁷⁴ See, for example, Friedman (2005) which examined the alignment between physicians’ confidence in their diagnoses and its correctness; of subjects who were faculty members, 32% exhibited high confidence in a diagnosis which was, in fact, erroneous.

The scale of the problem can be appreciated if one contrasts ‘high confidence’ as a predictor of accurate diagnoses (2 in 6 cases incorrect; 4 in 6 cases correct) with the toss of a coin (3 in 6 cases incorrect; 3 in 6 cases correct). See also Appendix F.

could be applied in psychiatry when a subject's illness is classified as depression, for example, rather than as bipolar disorder. I use the term '*technical misdiagnosis*' to refer to such cases provided that the validity of the psychiatric diagnostic category is uncontentious; where validity is in question then the assessment that the subject was 'mentally ill' [the 'pre-diagnosis'] may itself be erroneous.

C.1.2: Erroneous psychiatric 'pre-diagnosis'¹⁷⁵

The issue as to whether someone is suffering from an illness doesn't normally arise in general medicine; in psychiatry, however, the determination that a subject is 'mentally ill' may, in itself, be in contention. Indeed the very fact of a subject disputing his 'illness' may become evidence of his being mentally ill. For example, a medical diagnostician who can find no evidence of illness in a subject who has complained of a (non-psychiatric) illness, may consider the 'illness' to be psychosomatic and thus psychiatric in nature; conversely, a subject who disputes a psychiatric diagnosis, may be considered to 'lack insight' into his condition and this, in itself¹⁷⁶, may become further evidence of the presence of psychiatric illness.¹⁷⁷

An erroneous pre-diagnosis may have more serious consequences for a subject than a technical misdiagnosis in that it may, of itself, precipitate a coercive intervention.

The situation of a subject with a psychiatric pre-diagnosis is complicated by the fact that such a determination does not necessarily imply that the subject has *any* 'psychiatric illness' where that term is understood as encompassing the diagnostic categories detailed in diagnostic manuals such as the *DSM-IV* or the *ICD-10*.

Such a situation is to be distinguished from that of the subject who has a mental disorder, but who – because of difficulty in carrying out a differential diagnosis – has not yet been diagnosed as suffering from a *specific* psychiatric illness; a similar such situation might occur in a non-psychiatric medical setting, when a patient is suffering from a fever but it is not clear yet whether he is suffering from a malarial or some other fever. The situation being discussed here is where a subject is diagnosed as being mentally ill but despite exhaustive scrutiny does not fit into *any* of the psychiatric

¹⁷⁵ Smith's (1978) analysis (*supra*) of a case of psychiatric pre-diagnosis shows that it was also open to being interpreted as a case of some flat mates bullying or 'freezing-out' one of their number.

¹⁷⁶ Schwartz (1998): "*Poor insight has been reported as a common phenomenon which may have both ontological and prognostic value.*"

¹⁷⁷ Denial is a symptom of schizophrenia: *DSM-IV-TR* (2000), p.304: "*Evidence suggests that poor insight is a manifestation of the illness itself rather than a coping strategy. It may be comparable to the lack of awareness of neurological deficits seen in stroke, ...*"

See also Amador (2006) who states that "*poor insight*" has been found to be "*among the 12 'most discriminating' symptoms for differentiating schizophrenia from other mental disorders.*"

diagnostic categories; such cases were envisaged by Watler in the Amy case¹⁷⁸ and by Spitzer & Fleiss (1974).¹⁷⁹ This would imply that a distinction must be drawn between ‘*mental illness*’ and ‘*psychiatric illness*’.¹⁸⁰

C.1.3: Erroneous psychiatric assessment of dangerousness

A psychiatrist who assesses a subject as posing a danger to others is using his psychiatric expertise to predict how the subject’s illness may make itself manifest with respect to one particular aspect: its dangerousness; consequently, if such an assessment is erroneous, the assessment could be classed as being a ‘psychiatric misdiagnosis’.

Psychiatric assessments of dangerousness are discussed in Chapter 6 and in Appendix F where the conclusion is drawn that because of the high possibility that many standard techniques of risk assessment generate false positives, such assessments of dangerousness are, generally speaking, unreliable.

C.1.4: Non-purposeful misdiagnosis

Reich (1994) distinguished psychiatric misdiagnoses resulting from mistakes or inadequate professional knowledge from, what he termed, ‘*non-purposeful misdiagnoses*’;¹⁸¹ he believes that such misdiagnoses “*deserve the greatest scrutiny*”:

... because most misdiagnoses belong in this category. ... [and] involves in the main, non-medical needs, pressures, and compromises that affect the diagnostic process but enter the psychiatrists awareness to only a partial degree. The fact that psychiatrists allow themselves, for their own comfort, to ignore this awareness, or their responsibility to strengthen it, raises this category of misdiagnosis to the highest level of ethical concern.¹⁸²

Some examples of non-purposeful misdiagnosis

Example (i): Oliver (2008) describes the practice of using non-purposeful misdiagnosis in the care of the elderly whereby medical diagnostic decisions are made for reasons other than the interests of the subject.

¹⁷⁸ See Appendix C.

¹⁷⁹ Spitzer & Fleiss (1974), p.346:

... the necessity for an ‘undiagnosed psychiatric disorder’ category for those patients who do not meet any of the criteria for the specified diagnoses. In actual use, this category is applied to 20–30 per cent of newly-admitted in-patients.

¹⁸⁰ How do these categories relate? Is one a subclass of the other? The psychiatrist Watler [see the Amy case (*supra*)] clearly believes that one can be mentally ill without being psychiatrically ill.

Does the converse hold: can one be psychiatrically ill without being mentally ill? Initially one might think not until the very wide scope of the psychiatric disorders becomes apparent: *e.g.* ‘Mathematics Disorder’ [DSM-IV-TR (2000), p.53.]

¹⁸¹ *Op. cit.*, p.194:

[these] result from a process in which a psychiatrist has both adequate information about the patient and the illness and proper training, but issues an incorrect diagnosis because of factors extrinsic to the patient – and does so without being aware, or fully aware, that he or she is doing so.

¹⁸² *Ibid.*

Example (ii): Anaf & Halasz (2002) described how the diagnosis of ADHD may be influenced by parental, or teacher, pressure or by financial considerations.

Example (iii): Rost *et al* (1994) found that 31% of depressed patients received alternative codes to facilitate health insurance reimbursement.

Example (iv): Kirk & Kutchins (1992) suggest that the practice is not restricted to particular diagnostic categories.¹⁸³

One explanation for the apparent indifference to deliberate misdiagnosis is that both under- and overdiagnosing are justified as either harmless or in the client's best interest ... The manifest function of underdiagnosis is to protect clients; with overdiagnosis, the accurate diagnosis is replaced by a deliberately inaccurate one to deceive others. In particular, misdiagnosis is used so that the therapist's services will qualify for third-party reimbursement.¹⁸⁴

C.1.5: Under/Overdiagnosis

The terms 'underdiagnosis' [*i.e.* 'false negative'] and 'overdiagnosis' [*i.e.* 'false positive'] are common in the psychiatric literature and although they indicate the occurrence of a psychiatric misdiagnosis, they are less pejorative. Indeed the term 'overdiagnosis' appears at first glance, to be a purely technical term of little importance, however (as mentioned earlier) its true import becomes readily apparent – especially in the context of a coercive intervention – if one were to similarly describe a wrongful conviction in a criminal trial, as an 'overconviction'.

The term 'underdiagnosis' is itself ambiguous (as is the term 'overdiagnosis') in that it may imply either that the clinical psychiatrist has interpreted the diagnostic criteria in too lax a fashion or that the criteria themselves are too loosely drawn.¹⁸⁵

C.1.6: Radical misdiagnosis

The term '*radical intervention*' was used in Chapter 1 to refer to those coercive psychiatric interventions which resulted in damage to, or diminishment of, the personhood of the subject; by analogy, I wish to use the term '*radical misdiagnosis*' to refer to a psychiatric misdiagnosis which precipitated a radical intervention – the intervention being such that it would not have occurred in the absence of the misdiagnosis.¹⁸⁶ Not all coercive interventions are radical interventions and similarly not all psychiatric misdiagnoses (even if they precipitate a coercive intervention) are

¹⁸³ Though they speak of "*deliberate misdiagnosis*".

¹⁸⁴ Kirk & Kutchins (1992), pp.238-9.

¹⁸⁵ See *infra*.

¹⁸⁶ For example, the misdiagnosis of a subject as schizophrenic rather than depressive, the diagnosis of schizophrenia then precipitating a radical intervention (which would not have occurred had the correct diagnosis of depression been made).

radical misdiagnoses. The Juklerød and Manweiler cases provide examples of radical misdiagnoses.

An estimate of the prevalence of radical misdiagnoses¹⁸⁷ would be of considerable assistance to the development of the dissertation argument. Though a direct estimate is not available, an indirect estimate is possible based on:

- (i) The probability that a given psychiatric diagnosis which precipitates a coercive psychiatric intervention, is a misdiagnosis.
- (ii) The probability that a given coercive intervention damages or diminishes personhood (*i.e.* is a radical intervention).

The first of these problems will be discussed later in this chapter; the second will be discussed in Chapter 7.

C.2: Some sources of misdiagnosis particular to psychiatry

C.2.1: Additional inclusivity of the term ‘diagnosis’

As discussed in the previous section, the term ‘misdiagnosis’ has a wider ambit in psychiatry than in general medicine, consequently the prevalence of psychiatric misdiagnosis may be expected to be greater than in general medicine.¹⁸⁸

C.2.2: Absence of definitive tests

In general medicine, although the determination that a diagnosis was a misdiagnosis may present considerable difficulties in individual cases, evidence-based mechanisms exist to establish whether a particular diagnosis was erroneous.

In psychiatry, in contrast, there is an absence of biological, chemical, neurological or other definitive tests for *any* psychiatric illness.¹⁸⁹

A further complication arises in relation to a review of a psychiatric diagnosis carried out some time after the original diagnosis, in that the factual circumstances with which the psychiatric diagnostician is originally presented cannot be frozen in time¹⁹⁰ (unlike those which gave rise to a diagnosis of cancer where biopsy samples and X-rays may be

¹⁸⁷ *I.e.* an estimate of the likelihood that a given radical intervention is grounded in a misdiagnosis.

¹⁸⁸ If the default presumption is made that the likelihood of a technical misdiagnosis is the same in psychiatry as in general medicine.

¹⁸⁹ See, for example, First & Zimmerman (2006) (*supra*).

¹⁹⁰ Contemporaneous video recording of diagnostic interviews (such as occurs in relation the questioning of a suspect by the police) would go some way to enabling an independent review.

preserved) and hence – except in the most singular of circumstances – cannot¹⁹¹ be revisited for the purposes of conducting a full independent review.

The lack of definitive diagnostic tests also increases the likelihood of a reviewer deferring to a colleague’s professional opinion¹⁹² – e.g. the ‘*confirmation bias*’¹⁹³ and ‘*informational cascades*’¹⁹⁴ – especially when it appears possible to avoid asserting that the original diagnosis was erroneous (and thus assuage a colleague’s self-regard) by concluding that the original diagnosis was correct but that the disease is now in remission. Whereas, when viewed from the perspective of the psychiatric profession, such a course of action may provide a resolution to a case of suspected misdiagnosis; when viewed from the perspective of the misdiagnosed subject it fails utterly as the Juklerød case amply demonstrates.

The Lourdes Inquiry¹⁹⁵ provides compelling evidence of the existence of a culture amongst Irish medical professionals, not only of unwillingness to acknowledge medical malpractice and misdiagnosis, but to actively conceal such errors. In view of the resistance displayed by the psychiatric profession to the introduction into Irish law, of mechanisms to enable the review of psychiatric committal decisions,¹⁹⁶ there is scant

¹⁹¹ Except in the most unusual circumstances (as happened in the Manweiler case) contemporaneous case notes suggesting that the original diagnosis was erroneous are unlikely to exist.

¹⁹² Reich (1999), p.213:

Perhaps the most remarkable property of diagnosis, and sometimes the most enraging for the diagnosed patient, is its capacity for inevitable self-confirmation. That property is used in everyday life by persons who call others ‘crazy’ or ‘weird’: once they do so, everything that the receivers of such lay diagnoses do can be attributed to, and dismissed as a result of, those or similar psychopathologizing epithets. In fact, everything they do subsequently can become a proof that the original assessment was correct. This ‘catch-22’ quality of the pathological naming therefore functions with even greater efficiency and inevitability within psychiatry itself.

See also Rosenhan (1973) (*supra*).

¹⁹³ *Supra*.

¹⁹⁴ The term originated in economics where it was used to describe how individuals tend to conform to the judgement of others even when they believe these to be erroneous; see, for example Bikhchandani (1992). The Nyberg report [Nyberg (2011)] on the failure of the Irish banking system used the terms “*groupthink*” and “*herding*” to describe a similar phenomenon:

— A minority of people indicated that contrarian views were both difficult to maintain during the long boom and unhealthy to present to boards or superiors. A number of people stated that had they implemented or consistently supported contrarian policies they may ultimately have lost their jobs, positions, or reputations. (p.iii)

— The Commission both detected and inferred signs of widespread herding and groupthink (including “disaster myopia”) in Irish banks during the Period. (p.48)

¹⁹⁵ Harding-Clarke (2006) and also Appendix I.

¹⁹⁶ Mary Raftery, the journalist who was instrumental in bringing to light the abuse of children in Irish Industrial schools, has described the circumstances which ensured that the 1981 Act (though fully enacted) never had the force of law because it awaited a ministerial signature which was never made:

That Act had been voted through in the teeth of opposition from psychiatrists, who regarded the establishment of independent tribunals (with non-medical members) to review their diagnoses and committal orders as an unwarranted interference in their professional expertise.

Raftery continues:

Which brings us neatly to the *Mental Health Act*, 2001, trumpeted as the solution to all problems around involuntary committal. But, lo and behold, almost four years later, the critical sections of

reason to believe that the Irish psychiatric profession would be any more forthcoming than the obstetrical.¹⁹⁷

C.2.3: Lack of judicial supervision

In order to seek redress for harm occasioned by a psychiatric intervention a plaintiff must, under Irish Law, first seek the leave of the High Court to institute proceedings and, if such leave is granted, can only succeed in a civil action if the court is satisfied that “*the defendant acted in bad faith or without reasonable care;*”¹⁹⁸ this precludes action against a psychiatrist who was simply negligent in his diagnosis. No such limitation exists on a plaintiff in relation to a non-psychiatric medical diagnosis or intervention.

A glance at any textbook on medical law¹⁹⁹ will show how the law of negligence has affected general medical practice. It has, for example, had beneficial consequences in relation to improving standards of diagnosis, treatment and record keeping; the knowledge that one’s diagnostic decisions may be subject to subsequent scrutiny by a court of law, exerts a profound discipline. Conversely, the knowledge that a psychiatric misdiagnosis is, essentially, exempt from legal scrutiny or review may be expected to invite a certain laxity.

Aside from commencing a civil action for damages, one who is subjected to a coercive psychiatric intervention may also institute *habeas corpus* proceedings. Whilst in rare instances²⁰⁰ such proceedings may result in the release of the subject from their confinement, they do not provide a mechanism whereby the diagnosis itself may be challenged. If the mental hospital authorities release the subject prior to the hearing, this will conclude the proceedings; if they seek to justify the detention then the courts

this Act dealing with patient rights and safeguards have not yet been enacted ... And the reason? Yes, you guessed it – opposition from the psychiatric profession. Twenty-five years after they successfully stymied the 1981 Act, they’re at it again. They are refusing to participate in the three-person tribunal system, designed to review each involuntary committal.

Raferly, M. (2005). ‘Psychiatric profession at it again’. *The Irish Times*. 26 May.

¹⁹⁷ It should be noted that the Lourdes Inquiry found no evidence of bad faith on the part of Dr. Neary and, had the events in question occurred in a psychiatric setting, the absence of *male fides* would be a substantial bar to a patient taking a civil action against Dr. Neary.

¹⁹⁸ *Mental Health Act* (2001), S. 73(3).

¹⁹⁹ See, for example, Grubb (2004).

²⁰⁰ Hoggett (1990) cites authority for the proposition that detention for psychiatric treatment is lawful provided the documents are properly completed even though (as in the instant case) there might have been a “*terrible hinterland which demonstrates that it should not have been done*”. (p.255)

In relation to Irish Law, Keys (2002) states:

Yet a total of 111 applications by, or on behalf of psychiatric patients over an 85 year period hardly suggests an effective and accessible means of review of psychiatric detention. This is especially so when one considers that this figure was exceeded in a two year period in 1998-1999 by 113 prisoner applications. (p.36)

will not intervene provided the hospital authorities can show that the formalities of the law have been complied with.

Under the Irish *Mental Health Act* (2001), one who is subjected to a coercive psychiatric intervention is entitled to have his committal reviewed by a Mental Health Tribunal within 21 days of his detention; such a review requires that a consultant psychiatrist nominated by the tribunal examine the case. In the event that the tribunal is not satisfied that the subject is “*suffering from a mental disorder*”, it shall direct his release.²⁰¹ O’Neill (2005) suggests that the extent of time scales involved “*may render the patient’s right to review by the Tribunal illusory.*”²⁰² Furthermore, whereas the Tribunal has the power to order the release of a subject on the grounds that (at the time of the Tribunal hearing) they are not suffering from a mental disorder, it does not appear to have the right to rescind the original diagnosis; thus, the tribunal’s decision to order the release of a subject is compatible with both:

- the diagnosis which grounded the subject’s original committal was a misdiagnosis, and
- the original diagnosis was correct but at the time of the Tribunal hearing the subject’s mental illness is in remission.

The Juklerød case shows the importance of distinguishing between these alternatives and also highlights the necessity of examining the principles that should underlie the making of default presumptions in situations where there is insufficient evidence to enable the drawing of firm conclusions; *i.e.* if there is some – but not conclusive – evidence of a psychiatric misdiagnosis, should the decision be to exonerate the subject from the possibility of stigma or to exonerate the subject’s psychiatrist from the possibility of blame?

C.2.4: Vagueness of some diagnostic criteria

The vagueness of some diagnostic criteria has been noted in earlier discussion, especially in relation to the diagnosis of delusion (and the distinction between bizarre and non-bizarre delusions and, in consequence, the diagnosis of schizophrenia).²⁰³ The existence of such imprecision clearly increases the possibility of misdiagnosis (howsoever defined). Paradoxically however, it also increases the possibility that, in such cases, the original misdiagnosis cannot be shown to be erroneous.

²⁰¹ *Mental Health Act* (2001), S. 18.

²⁰² O’Neill (2005), p.404.

²⁰³ See *supra*.

C.2.5: Poor reliability of psychiatric diagnoses

As discussed earlier in this chapter, poor diagnostic reliability necessarily implies the existence of high levels of psychiatric misdiagnosis.

Conflicts of psychiatric evidence in criminal trials provide ample and eloquent confirmation of poor diagnostic reliability. For example, in the Brendan O'Donnell case²⁰⁴ which was the longest running criminal trial in the history of the Irish State²⁰⁵, the court was "... *scathing [in its] criticism of psychiatric professionals.*"²⁰⁶

In this case there was an irreconcilable conflict between the expert evidence of different psychiatrists:

(i) Dr. Brian McCaffrey, a consultant psychiatrist, testified that:

Mr. O'Donnell had a very serious disease of the mind and did what he had done "*directly as a result of a schizophrenic illness*". ... The witness read the WHO definitions of schizophrenia and HS²⁰⁷ to the court. He said Mr. O'Donnell met the WHO criteria for schizophrenia very easily. He also filled the criteria for HS "*as clearly as you can get it in anybody*". Dr. McCaffrey said it was his view that Mr. O'Donnell had HS since at least 1991. ... He had no doubt about his diagnosis.²⁰⁸

(ii) In contrast Dr. Charles Smith, a psychiatrist and Head of the Central Mental Hospital, told the court that he believed he had no illness to treat in Mr. O'Donnell's case and there was "*a lot of acting out behaviour*".²⁰⁹

The existence of such extreme conflicts in such a public forum as a High Court trial raise considerable doubts as to the validity and consistency of psychiatric diagnosis made in circumstances less open to public scrutiny.

C.2.6: Questionable validity of some psychiatric diagnostic categories

As discussed earlier in this chapter, some psychiatric diagnostic categories are of questionable validity; it is clear that a subject who is diagnosed as having a specific psychiatric illness (which is subsequently held to lack validity), has been subjected to a psychiatric misdiagnosis. Thus the diagnosis of a homosexual subject as being mentally

²⁰⁴ Brendan O'Donnell was jailed for life in Dublin for the murder in 1994, of Imelda Riney, her son and a priest.

²⁰⁵ The Irish Times (1996) 'Hospital head found O'Donnell was "close to psychosis" at 14'. *The Irish Times*, March 21.

²⁰⁶ As reported in the *British Medical Journal*. [Murdock (1996)].

²⁰⁷ Hebephrenic schizophrenia (HS).

²⁰⁸ The Irish Times (1996). 'Psychiatrist tells court of O'Donnell mental disorder in Riney killing'. *The Irish Times*, March 14.

²⁰⁹ The Irish Times (1996) 'Ballinasloe hospital's handling of O'Donnell criticised by doctor'. *The Irish Times*, 26 March.

ill solely by virtue of his homosexuality, can unquestionably²¹⁰ be described as a psychiatric ‘misdiagnosis.’

One consequence of this and similar examples²¹¹ of committals based on psychiatric diagnoses which were subsequently adjudged to be invalid either in the absence of – or, occasionally, in defiance of – a consensus²¹² of psychiatric professional opinion, is that estimates of the extent of psychiatric misdiagnosis, made from the perspective of professional psychiatry, will generally underestimate the extent of the problem.

The conclusion that estimates, by psychiatrists, of the extent of psychiatric misdiagnosis, should – in the absence of explicit evidence to the contrary²¹³ – be regarded as underestimates, also receives confirmation from a consideration of two possible responses to a subject’s contention that his psychiatric diagnosis was a misdiagnosis: namely that he is ‘in denial’ or that his illness is, presently, ‘in remission’.

C.2.7: ‘Denial’ and ‘remission’ in relation to psychiatric misdiagnosis

The terms ‘in denial’ and ‘in remission’ are common in general medicine: a woman who has just been diagnosed with breast cancer²¹⁴ may refuse to accept her diagnosis and may be said to be ‘in denial’. In the event that the cancer was successfully treated, the woman’s cancer may be said to be ‘in remission’.

The woman who disputes her diagnosis of breast cancer may engage her own independent consultant and having reviewed the original diagnostic tests and biopsies, she may decide whether, or not, to pursue treatment. If, subsequently, her cancer is

²¹⁰ See *supra*.

²¹¹ Such as Soviet dissidents (*supra*) and the case of Hannah Greally [see Ward (2006)].

An example given by Judge McCartan, then a TD (Dail Debates 5 May 1992) has an especial authority in that as a judge of the Circuit Court he would have jurisdiction to decide appeals from decisions of the Mental Health Tribunals under the *Mental Health Act* (2001):

... One of my first cases involved ... a man from the west who was lodged in the Central Mental hospital in Dundrum. He wrote to me and I went to see him. He explained that because of a marital disagreement between himself and his wife she had literally got to the local priest and doctor quicker than he had ... and by one device or another he ended up in a district mental hospital.

There, protesting to the resident medical superintendent his innocence and sanity, he was simply ignored and spurned. As the resident medical superintendent turned on his heel to walk away, this patient picked up a stone, threw it in his direction and missed. Nonetheless he was charged with the offence of common assault [and] ... ended up in Dundrum Central Mental Hospital. That was in 1953. In 1975, 22 years later, I met that man, sane as the day he went in but, unfortunately, at that stage very institutionalised ...

²¹² See ‘groupthink’ *supra*.

²¹³ See the Precautionary Principle *supra*.

²¹⁴ Or a subject who has just been diagnosed with a terminal illness; see Kübler-Ross (1975):

Denial—“*No, not me.*” This is a typical reaction when a patient learns that he or she is terminally ill. Denial ... is important and necessary. It helps cushion the impact of the patient’s awareness that death is inevitable. (p.10).

diagnosed as being ‘in remission’, this diagnosis is predicated on the existence of definitive evidence that the cancer actually existed at the time of her initial diagnosis. Consider a comparable situation in psychiatry where a subject who is diagnosed as schizophrenic disputes his diagnosis. Whilst the misdiagnosis of schizophrenia is a not uncommon phenomenon,²¹⁵ yet the fact that the subject disputes such a diagnosis is tantamount to a ‘denial’ and becomes of itself further, and independent, evidence of the correctness of the diagnosis.²¹⁶ By disputing his diagnosis he thereby provides confirmation of it – truly a ‘*Catch 22*’.²¹⁷

A search of the academic literature for studies on psychiatric misdiagnosis (the results of which are discussed in *Appendix M*) yielded surprisingly few results, the most relevant to the present context were a series of papers written by some Israeli psychiatrists which found:²¹⁸

– The labelling and stigma resulting from misdiagnosis have severe implications and there is inherent difficulty in correcting misdiagnoses of major psychiatric disorders. We present a 38-year-old man who underwent numerous psychiatric and psychological examinations in order to change a previous misdiagnosis. The difficulties examiners had in accepting the possibility of misdiagnosis, and its severe consequences, are described.²¹⁹

– ... a psychiatric diagnosis had been made and malingering suspected, although the patient actually had a severe neurological disorder. The psychiatric diagnosis had not been changed despite recurrent medical and psychological examinations which clearly indicated a physical disorder. The difficulties that follow misdiagnosing organic disorders as psychiatric disorders are illustrated.²²⁰

The extreme difficulty²²¹ encountered in having a psychiatric diagnosis acknowledged as erroneous, has been attested to by other academic commentators such as Reich (1999) (*supra*) and Rosenhan (1973) (*supra*).

²¹⁵ See, for example, Hickling (1999) (*supra*).

²¹⁶ See *supra* and also Amador & Strauss (1993): “*In work with patients with schizophrenia, denial of illness is so common ... that it has become integral to our concept of this disorder.*”

Amador was co-chair of the final revision of the *DSM-IV-TR* (2000).

²¹⁷ See Reich (1999) (*supra*) on this aspect of psychiatric diagnosis.

²¹⁸ As the papers were written in Hebrew only the abstracts have been consulted; however a further paper [Witztum (1995b)] is in English and is discussed *infra*.

²¹⁹ Margolin (1995).

²²⁰ Witztum (1995).

²²¹ See, for example, an address entitled “*Complaining is a Right - Not a Symptom*”, given by the Ombudsman to the Mental Health Ireland Annual Conference (2004) which highlighted the extreme difficulty faced by mental patients in making complaints concerning their treatment. Responses to such complaints often:

...cast[ing] doubt on the complainants' account by labelling them a ‘*bad patient*’ and arguing that dissatisfaction is a symptom of the illness being treated. ... With certain exceptions I have rarely found that health professionals, particularly doctors and consultants, engage wholeheartedly with patients' complaints.

[online], available: <http://ombudsman.gov.ie/en/Speeches/Name,2164,en.htm> [accessed: 2 September 2008].

Rosenhan, when interviewed in 2007, stated:

The only way out was to point out that they're correct. They said I was insane, I am insane, but I am getting better. That was an affirmation of their view of me.²²²

The adoption of such attitudes by psychiatrists is tantamount to a denial of the possibility of the occurrence of psychiatric misdiagnosis and is indicative of a level of professional arrogance reminiscent of the medieval church and its requirement of heretics that they recant, or of the requirement that prisoners abjure any claim to innocence as a precondition for parole.²²³

In summary, I wish to draw the conclusion that clinical diagnosis is more open to error in psychiatry than in general medicine due to a number of factors:

- (i) Additional inclusivity of the term 'diagnosis';
- (ii) Absence of definitive tests;
- (iii) Lack of judicial supervision;
- (iv) Vagueness of some diagnostic criteria;
- (v) Poor reliability of psychiatric diagnoses;
- (vi) Questionable validity of some psychiatric diagnostic categories;
- (vii) 'Denial' and 'remission' as rebuttals to claims of psychiatric misdiagnosis.

The existence of any possible countervailing factors is not immediately evident.

Section D: Estimates of rates of psychiatric misdiagnosis

A number of authoritative studies have estimated the rate of misdiagnosis occurring in non-psychiatric medical practice. These studies have drawn mainly on data from the US and the UK but some of the results have been extrapolated to Ireland. Some of these studies are discussed in *Appendix I* where the conclusion is drawn that the rate of misdiagnosis in general medical practice in Ireland is in the region of 25%.

These estimates relate solely to non-psychiatric medical practice. In an attempt to locate similar estimates of the rate of psychiatric misdiagnosis, journal searches were undertaken of medical non-psychiatric journals,²²⁴ medical databases²²⁵ and psychiatric journals²²⁶ for occurrences of terms such as '*psychiatric misdiagnosis*'. The results of these searches are detailed in *Appendix M*.

²²² Curtis & Lambert (2007).

²²³ See Aeberhard (2010) which reports on the posthumous pardon of one who had been convicted of rape but who, because he continued to maintain his innocence, had been denied parole and died in prison. Aeberhard, D. (2010). 'Texas 'rapist' granted state's first posthumous pardon.' *BBC*. 2 March. [online], available: <http://news.bbc.co.uk/2/hi/americas/8544890.stm> [accessed: 30 March 2010].

²²⁴ *The British Medical Journal*; *The Lancet* and *The New England Journal of Medicine*.

²²⁵ PubMed and MEDLINE.

²²⁶ *The American Journal of Psychiatry* and *The British Journal of Psychiatry*.

From the perspective of the dissertation argument, the optimum outcome of these journal searches would have been:

A: A definitive estimate of the rate of those coercive psychiatric interventions that had been grounded in a psychiatric misdiagnosis (*i.e.* the rate of radical misdiagnosis);

Failing that, it would have been of considerable assistance to uncover:

B: A definitive estimate of the rate of general psychiatric misdiagnosis (*i.e.* across all psychiatric diagnostic categories).

Neither estimate was found.

Although the searches did not elicit the hoped for information, they did bear fruit and a number of conclusions are detailed in Subsection D.1. Some alternative indicators as to rates of psychiatric misdiagnosis are examined in Subsection D.2. The misdiagnosis of physical illness as psychiatric, is discussed in Subsection D.3. Some estimates of the prevalence of psychiatric misdiagnosis (other than schizophrenia) are suggested in Subsection D.3; and in relation to schizophrenia, in Subsection D.5.

D.1: Journal search results: three conclusions

D.1.1: The absence of data on psychiatric misdiagnosis

Searches in leading medical journals and databases for occurrences of the phrase 'psychiatric misdiagnosis' *anywhere* in a journal article yielded:

<u>Journal</u>	<u>Dates</u>	<u>Results</u>
<i>The British Medical Journal</i>	1994 – 2008	1
<i>The Lancet</i>	1996 – 2008	0
<i>The New England Journal of Medicine</i>	1993 – 2008	0
<i>PubMed</i>	unrestricted	12
<i>MEDLINE</i>	1975 – 2007	9

Table 4-1: Journal occurrences of the term 'psychiatric misdiagnosis.'

Searches in leading psychiatric journals for occurrences of the term 'misdiagnosis' in a journal title or abstract yielded:

<u>Journal</u>	<u>Dates</u>	<u>Results</u>
<i>The American Journal of Psychiatry</i>	1844 – 2008	19
<i>The British Journal of Psychiatry</i>	1855 – 2008	13

Table 4-2: Journal occurrences of the term 'misdiagnosis.'

In that the searches of both psychiatry journals covered in excess of 150 years and spanned periods when psychiatric misdiagnosis was a topic of sustained controversy in the public media,²²⁷ the dearth of research is, of itself, of note and when allied with the lack of direct research (as distinct from reviews of the literature) into the possible

²²⁷ *E.g.* (*supra*) the Rosenhan study, the misdiagnosis of Soviet political dissidents, the existence of gross disparities in diagnostic rates for schizophrenia between Blacks and Whites and between US and UK subjects.

misdiagnosis of Black Americans,²²⁸ suggests the conclusion that the absence of research may be indicative of a professional unwillingness to acknowledge the possibility of psychiatric misdiagnosis.

To draw such a conclusion solely on the absence of research studies may appear overhasty yet it can also be supported on other grounds:

- the nature of the analysis on studies on race and misdiagnosis (*supra*) and especially the results of a survey of UK psychiatrists²²⁹ in so far as it relates to the existence of a racial basis for misdiagnosis;
- a series of papers by Witztum and others (*supra*), in particular Witztum (1995b) (*infra*).

D.1.2: Some research on race and misdiagnosis

Of the six studies on race and misdiagnosis mentioned in Appendix M²³⁰ three²³¹ were written after the publication of Hickling (1999)²³² – a particularly important study in that it sought to directly examine the possibility that the high rates of schizophrenia diagnosed in the UK immigrant communities might be due to an (unconscious) racial prejudice amongst white psychiatrists. Yet only one of the three studies refers to Hickling (1999).²³³

Though Hickling (1999) was inconclusive in relation to whether misdiagnosis was occasioned by racial factors,²³⁴ it was unequivocal as to the existence of high rates of misdiagnosis of schizophrenia.

The existence of racial prejudice in relation to diagnosis was subsequently confirmed from an unexpected source – an authoritative survey²³⁵ of UK psychiatrists which,

²²⁸ Neighbors (1997), p.3:

Adebimpe (1981) made this point many years ago when he criticized the research community for not doing more to investigate the possible misdiagnosis of African Americans:

It is therefore, remarkable that these allegations (of misdiagnosis) have not been extensively and rigorously examined. Almost a decade after they were first made, there exists only a modicum of data by which they can be evaluated. (Adebimpe, 1981, p.279).

Adebimpe's statement is as accurate today as it was 15 years ago.

²²⁹ Kingdon (2004) *supra*.

²³⁰ See Subsection M–2(ii).

²³¹ Singh (2007), Sharpley (2001) and Bhugra (2001).

²³² To recap: Hickling (1999) compared the diagnoses of a group of patients by British and subsequently by Jamaican, psychiatrists; in relation to the diagnosis of schizophrenia, they disagreed on 45% of the diagnoses.

²³³ Sharpley (2001):

... interestingly, the diagnoses of the British psychiatrists and the African-Caribbean psychiatrist agreed in only 55% of cases. Thus, this study indicates that the routine clinical diagnosis of schizophrenia is not a reliable one, but provides no evidence that it is applied in a racially biased manner. (s60).

²³⁴ Hickling in a subsequent analysis [Hickling (2005)] concluded that: “*The etiological evidence is shifting toward factors of racism and social alienation experienced by black people in the UK, and to misdiagnosis by white British psychiatrists.*” (p.256).

judging from the context,²³⁶ is authority for the proposition that psychiatrists believe that *other* psychiatrists *often*²³⁷ misdiagnose schizophrenia; a finding which not only casts doubt on the psychiatrists own reliability but bespeaks a level of denial.²³⁸ It also suggests that reports of psychiatric misdiagnosis underestimate the extent of the problem.

The study was silent about psychiatrists' beliefs as to their own propensity to misdiagnose or their willingness to revise an earlier diagnosis made either by themselves or by a colleague. The papers discussed in the following subsection shed some light on this latter question.

D.1.3: Professional unwillingness to reverse a misdiagnosis

In a series of papers,²³⁹ Witztum *et al* have highlighted:

1. The severe consequences that may be entailed by a psychiatric misdiagnosis especially a diagnosis of schizophrenia.²⁴⁰
2. The difficulty exhibited by psychiatrists in accepting that an earlier psychiatric diagnosis may have been incorrect²⁴¹ even in circumstances where examinations have clearly indicated a physical disorder as the source of the problem.²⁴²

Writing generally about aspects of the problem of misdiagnosis particular to psychiatry, Witztum (1995b) notes that:

In other specialities, however, safeguards exist for the verification of a diagnosis through additional, objective examinations. As yet this is impossible in psychiatry ... It is a cruel irony that the patient in an effort to rid himself or herself of a misdiagnosis may behave in ways that others view as further evidence of his or her illness.²⁴³

Witztum (1995b) gives a case history:²⁴⁴

‘A’ a 30 year old married father of two who, when aged 18 and in military service and because of anxiety in relation to his work, had been referred for psychiatric

²³⁵ Kingdon (2004).

²³⁶ Unfortunately a copy of the questionnaire was not included in the published paper.

²³⁷ *Op. cit.* 48% of psychiatrists interviewed considered it to be “common”. (*Supra*)

²³⁸ Kingdon (2004) (*supra*) explicitly cast doubt on studies which denied the existence of such racial bias: “*Misdiagnosis of schizophrenia in Black people is believed to be common ... This may be surprising in view of research studies, which have suggested such misdiagnosis to be uncommon ...*”

²³⁹ Witztum (1995a); Margolin (1995) and Witztum (1995b) [*supra*].

²⁴⁰ Witztum (1995b): “*The price of psychiatric misdiagnosis may be very high ... [and] probably best illustrated in those persons who bear the diagnosis of schizophrenia, the most stigmatising of all mental disorders.*” (p.663).

²⁴¹ Margolin (1995) (*supra*) and Witztum (1995b).

²⁴² Witztum (1995a) (*infra*).

²⁴³ Witztum (1995b), p.661; see also p.664:

In spite of the fact that the results of these repeated evaluations failed to show any signs of psychotic process, it was typically concluded the ‘*the abovementioned findings hint at a degree of psychotic impairment that is presently held in check by his basic obsessiveness.*’

²⁴⁴ Witztum’s vignette closely parallels the Juklerød case and Rosenhan study (*supra*).

evaluation. During this evaluation he had expressed suicidal ideation; this precipitated his hospitalisation and subsequent diagnosis as schizophrenic. Because of this diagnosis he was discharged from military service. His subsequent attempts to get employment were frustrated by his prospective employers becoming aware of his diagnostic record and insisting on further psychiatric evaluation. No less than five such separate psychiatric assessments were made ... all of them failing to reveal any significant findings, the early diagnosis of schizophrenia heavily prejudiced the impressions derived from subsequent evaluations. The diagnosis was extremely resistant to revision and continued to handicap Mr A's personal and professional life gravely.²⁴⁵

Unable to get satisfactory employment, 'A' decided to reapply to the military and was sent for assessment to two of the authors who concluded that the original diagnosis should be removed and "*should according to the DSM-IV probably have been a major depressive episode.*"²⁴⁶

Witztum (1995b) argues that the main issue is not:

... the specific nature of the misdiagnosis. Rather the issue is how an individual's life may be profoundly influenced by a single hospitalisation, by an inaccurate diagnosis ... and by the inability of the mental health establishment for many years to revise the diagnosis.²⁴⁷

Witztum's analysis shows that many of the problems portrayed in 1973 by the Rosenhan study, still lay unresolved.

This reluctance of psychiatrists to question earlier psychiatric diagnoses clearly impinges on reported rates of misdiagnosis, and permits the conclusion to be drawn that reported levels of psychiatric misdiagnosis should generally be regarded as being underestimates.

D.2: Some indicators as to general rates of psychiatric misdiagnosis

Spitzer & Fleiss (1974) (*supra*) spoke of:

... the obvious unreliability of psychiatric diagnosis ... [which was] no better than fair for psychosis and schizophrenia and is poor for the remaining categories.

As discussed earlier, such findings led to calls for the explicit formulation of sets of necessary and sufficient conditions for each diagnostic category and this was the focus of the *DSM-III*. But, as concluded earlier, poor diagnostic reliability was a continuing problem even under *DSM-IV* (2000).

Psychiatric diagnostic unreliability necessarily implies the existence of psychiatric misdiagnosis. Thus a discussion on current levels of psychiatric misdiagnosis has as a

²⁴⁵ Witztum (1995b), p.667.

²⁴⁶ *Ibid.*, p.669.

²⁴⁷ *Ibid.*, p.667.

starting point, a conceded high level of misdiagnosis; the problem is then to find estimates of this phenomenon.

One method of uncovering areas of possible psychiatric misdiagnosis is to compare the prevalence of the use of different diagnostic categories both over time and over geographical location; it was by using such methods that both the extent²⁴⁸ of – and possible role of racism in – the misdiagnosis of schizophrenia was brought to light.²⁴⁹ A number of studies exist which have examined variations between different regions within a particular country, and between different countries in:

- the prevalence of particular diagnoses such as schizophrenia, and
- the rates of involuntary committals.

Some of these studies focus on Ireland and compare prevalence rates between Health Board areas within Ireland [D.2.1]; some draw comparisons between Ireland and other European countries [D.2.2] whilst others have a more international focus [D.2.3]. The existence of extreme variations provides a *prima facie* indication of not insignificant levels of psychiatric misdiagnosis.

D.2.1: Ireland

Variations in diagnostic practices and committal rates which have been extracted from the annual reports of the Mental Health Commission [MHC] for the years 2004 [D.2.1.1]; 2005 [D.2.1.2]; 2006 [D.2.1.3], and 2007 [D.2.1.4] are discussed below.

D.2.1.1: 2004

MHC (2004) noted a five fold variation²⁵⁰ in admission rates²⁵¹ and a four-fold variation²⁵² in “*certification rates*”²⁵³ between various catchment areas.

D.2.1.2: 2005

MHC (2005) noted:

As with previous years, the largest single diagnostic group for residents was schizophrenia, followed by depressive disorders and mental handicap. Unfortunately, 15% of residents had no diagnosis returned. This is due in large part to the practice in some inpatient facilities of not recording a diagnosis until

²⁴⁸ Spitzer & Fleiss (1974) (*supra*).

²⁴⁹ Hickling (1999) (*supra*); a similar mechanism enabled the uncovering of the surgical abuses committed by Dr. Neary [see the discussion on the Lourdes Inquiry (*supra*)].

²⁵⁰ MHC (2004), p.111: “Admission rates vary from a high of 1,300 per 100,000 over the age of 16 in South Tipperary to a low of 270 per 100,000 population over the age of 16 in the Tallaght service.”

²⁵¹ *I.e.* voluntary and involuntary admissions.

²⁵² *Op. cit.*: “Certification rates vary by a factor of 4 between catchments and by a factor of 2 between HSE Areas (Health Boards), from a high of 101 per 100,000 ... to a low of 50 per 100,000 ... “

²⁵³ *I.e.* involuntary admissions.

discharge. As this is a census, the residents have not yet been discharged and therefore have no recorded diagnosis.²⁵⁴

In attempting to calculate rates of misdiagnosis, this lack of recorded diagnosis is clearly a hindrance.

The report also examined the involuntary hospital 'resident rate'²⁵⁵ by catchment area; these ranged from 6.0 to 44.0 per 100,000 of the population which is over a seven-fold variation.²⁵⁶

D.2.1.3: 2006

MHC (2006) tabulated the hospital resident rate (both voluntary and involuntary) by catchment area with variations ranging between 19.6 per 100,000 (Kildare and West Wicklow) to a high of 190.8 (Cork).²⁵⁷

The report also commented on how the involuntary admission rates were dependant on the differing methodologies adopted by different studies;²⁵⁸ it concluded that the involuntary admission rate for the year 2005 was 75.6 per 100,000 of population.

D.2.1.4: 2007

MHC (2007) is of particular interest in that it related to the first full year of implementation of the review provisions contained in the *Mental Health Act* (2001); it noted "a 25% reduction on the number of people admitted on an involuntary basis"²⁵⁹ and opined that further analysis was required to identify the reasons for a reduction of such magnitude.

The Mental Health Tribunals conducted 2,248 reviews in 2007, 11% of which resulted in the original order being revoked;²⁶⁰ 60% of these – *i.e.* 7% of all reviews²⁶¹ – concluded that the patient had no mental disorder at the time of the hearing.²⁶²

The 2007 report makes no mention of cases of possible psychiatric misdiagnosis.²⁶³

²⁵⁴ 34% of patients were diagnosed with schizophrenia – a rate of 39.2 per 100,000. [*MHC* (2005), Table 4.6].

²⁵⁵ The 'resident rate' refers to the number (per 100,000) resident in the hospital on the census night; the 'admission rate' refers to the number (per 100,000) admitted *per annum*.

²⁵⁶ 44.0 (per 100,000) in Dublin North West to 6.0 in Kildare and West Wicklow. [*MHC* (2005), Table 4.5.].

²⁵⁷ Excluding those outside the catchment area. [*MHC* (2006), p.49].

²⁵⁸ *MHC* (2006), p.36.

²⁵⁹ *MHC* (2007), p.8.

²⁶⁰ The principle reasons for revocation were:

- "Patient not suffering from mental disorder at time of hearing" (60%);
- "Provisions of the Act have not been complied with." (39%).

[*MHC*, (2007), Figure 3 and Table 17].

²⁶¹ *I.e.* 2248 x 0.11 x 0.60 = 148; 148 is 7% of 2248.

²⁶² Under the 2001 Act, a patient who is released before their scheduled hearing, can request that the hearing still take place; there were 16 such requests in 2007. [*MHC* (2007), p.42.].

In presenting the 2007 report, the chief executive of the MHC: "... expressed concern at the 15 per cent increase in patients being regraded from voluntary to involuntary status and said this must be investigated."²⁶⁴ This point is of interest in that it may shed some light on the practice of making a voluntary patient, involuntary, if they express an unwillingness to accept a proposed treatment. The Manweiler case provides an example of the use such a practice and one which was subsequently defended²⁶⁵ – if not advocated – by an eminent Irish psychiatrist; such a practice eviscerates the doctrine of consent and, if widely used, has the effect of rendering voluntary patients, *de facto* involuntary.

It seems not unreasonable to conclude²⁶⁶ that the implementation of the review provisions of the 2001 Act had the effect of reducing the number of involuntary committals by 33%;²⁶⁷ nor is it unreasonable to assume that in the absence of the review procedures the rates that had pertained in previous years would persist. If it is accepted that the involuntary committals which the implementation of the review procedures either prevented or reversed could be described as 'unwarranted'²⁶⁸ then it must be concluded that in years prior to the implementation of the review procedures a third of all involuntary committals were psychiatrically unwarranted.

It should not be assumed that the committals which would have been made in the absence of the review procedures, fully encompassed those whose psychiatric diagnosis was a misdiagnosis; such a conclusion could only be justified:

²⁶³ In fact none of the terms 'misdiagnosis', 'error', 'erroneous' or 'mistake' appear anywhere in the report.

Under the 2001 Act (as mentioned earlier) the tribunals do not appear to have the power to make a finding that the original diagnosis that precipitated a coercive intervention was erroneous; thus if a case similar to the Juklerød case were to arise in Ireland, the Mental Health Tribunal system could not provide an adequate resolution.

²⁶⁴ Healy, A. (2008). 'Concerns raised over condition of psychiatric hospitals'. *The Irish Times*. 30 May.

²⁶⁵ Dr. Kennedy (Director, The Central Mental Hospital): "I tend to listen to my patients and if they tell me that they are unhappy, I take it that they are not consenting." [See Appendix H].

²⁶⁶ Reliance may also be placed on the Precautionary Principle (*supra*).

²⁶⁷ *I.e.* If the population in the absence of the review procedures was 100 then a 25% reduction gives a population of 75 of which 11% (8.25) had their order reversed giving a final total of 66.75.

²⁶⁸ I have used the term '*psychiatrically unwarranted coercive interventions*' to cover coercive interventions grounded in either a specific psychiatric diagnosis which was erroneous or in a clinical judgement that an individual was mentally ill to the extent that a coercive intervention was appropriate but which in the view of the law or of the consensus of professional psychiatric opinion, was not appropriate.

The term is necessary because a practice exists in some Irish psychiatric hospitals where a psychiatric diagnosis is not made until the subject is discharged [see *supra*]; to speak of such a patient prior to discharge, as being 'misdiagnosed' is problematic.

The term is also meant to be contrasted with '*philosophically unwarranted coercive interventions*'.

- if it was shown that the reduction in the number of involuntary committals occurred in those cases where the clinician had low confidence in his diagnosis, and
- a high correlation was shown to exist between lack of confidence in diagnosis and misdiagnosis.

Studies²⁶⁹ on the relationship between clinical confidence and correct diagnosis show no such simple relationship.

The discussion in this subsection can be summarised in the following conclusion:

The implementation under the Mental Health Act (2001), of procedures for reviewing involuntary committals, had the effect of reducing, or reversing, the number of such orders by 33%. This suggests that in years prior to the implementation of the review procedures, at least a third of all involuntary committals in the Republic of Ireland were psychiatrically unwarranted.

D.2.2: Ireland compared to other European countries

A 2002 report of the European Commission compared the involuntary committal rate between various European countries.

In relation to Ireland, the report found that: “*The involuntary hospitalisation rate of approximately 70 per 100,000 of population far exceeds that of neighbouring western European countries.*”²⁷⁰

D.2.3: International studies

The European Commission report summarised its findings in relation to involuntary committal rates within the EC:

Whereas total frequencies of annual compulsory admissions of mentally ill patients differ enormously according to the differing populations of the Member States ... compulsory admission rates ... also vary remarkably, ranging from a mere six per 100,000 population in Portugal to 218 in Finland.²⁷¹

The situation in European countries outside the EU seems little different; for example, a Norwegian study²⁷² found a rate of compulsory admission of 147 per 100,000 inhabitants. A study of psychiatric admission practices in Scandinavia which compared rates of compulsory admission in Norway, Sweden, Finland and Denmark found “a

²⁶⁹ Friedman (2005) (*supra*); see also Sutherland (1992) (*supra*).

²⁷⁰ European Commission (2002), p.101.

It has been argued that some such differences in prevalence levels may be justified but this has, in turn, been contested. See, for example, Cabot (1990) who noted that “*Recent prevalence studies of schizophrenia claim that there is indeed a greater number of cases in the west of Ireland than in other parts of the world.*” but, having reviewed the underlying research, he concluded that it lacked reliability.

²⁷¹ European Commission (2002), p.154.

²⁷² Hatling (2002).

great variation in rates of compulsory care” with rates ranging from 14 per 100,000 to 99 per 100,000 – a seven-fold variation.

One Norwegian study found that the particular psychiatric service that the subject had been in contact with, was a better predictor of involuntary committal than the subject’s actual psychiatric diagnosis.²⁷³

The discussion in this and the previous subsection can be summarised in the following conclusion:

The extremely wide variations in rates of involuntary committal:

- within Ireland (four-fold);
- between Ireland and other EU countries (thirteen-fold greater than the lowest; the highest was three-fold greater than Ireland);
- between EU countries (‘forty seven’-fold);
- between Scandinavian countries (seven-fold);

are such as to be indicative of a lack of awareness within European clinical psychiatry of the seriousness of the consequences that such an intervention may entail and the consequent requirement for adequate, rigorously assessed, justification.

Such extreme differences in the prevalence rates of involuntary psychiatric detention provide *prima facie* grounds for concluding that, across Europe, the rate of psychiatric misdiagnosis precipitating coercive intervention, is substantial.

D.3: Physical illness misdiagnosis as psychiatric illness

As mentioned earlier, a full text search for occurrences of the term ‘psychiatric misdiagnosis’ in the *British Medical Journal* over a period of 25 years yielded a single result [Stone (2005)]; it defined its objective thus:

Paralysis, seizures, and sensory symptoms that are unexplained by organic disease are commonly referred to as "conversion" symptoms. Some patients who receive this diagnosis subsequently turn out to have a disease that explains their initial presentation. We aimed to determine how frequently this misdiagnosis occurs, and whether it has become less common since the widespread availability of brain imaging.

It is of interest to examine this study in detail because it sheds some light on the underreporting of cases of psychiatric misdiagnosis.

Stone (2005) concluded that:

A high rate of misdiagnosis of conversion symptoms was reported in early studies but this rate has been only 4% on average in studies of this diagnosis since 1970.

Introducing the study, the authors state:

Doctors often feel uneasy about making a diagnosis of conversion symptoms. This is, in part, due to the considerable influence of studies that have suggested that misdiagnosis is unacceptably common. The best known of these studies was

²⁷³ Hansson (1999).

published by Slater in 1965. It described a misdiagnosis rate of 33% in patients with “hysteria” and concluded with the memorable warning that the diagnosis was nothing more than “a delusion and a snare.”

Stone (2005), despite citing a 1965 study, does not refer to Hall (1980) – a study which has considerable relevance; it described how patients in a state psychiatric hospital:

... were intensively evaluated medically on a research ward for the presence of unrecognized medical illnesses that might have affected their hospitalization.²⁷⁴

Hall (1980) cited some earlier studies which had prompted his own study:

- one had highlighted the extent of undiagnosed physical illness amongst a group of psychiatric patients, in some of whom the psychiatric symptoms were *solely* attributable to their underlying physical disorders;
- a second study found that psychiatrists routinely fail to physically examine their patients and that “*a significant number of them feel uncomfortable with their ability to conduct such an examination*”.²⁷⁵

In Hall’s study, of the 100 patients examined:

... 46% had a previously unrecognized and undiagnosed medical illness that in our opinion was specifically related to their psychiatric symptoms or exacerbated them significantly. An additional 34% had unrecognized physical illness ... of the 46% ... 61% showed rapid clearing of psychiatric symptoms when their underlying disorder was treated.²⁷⁶

Of the 46%, a third had been diagnosed with schizophrenia.

Hall’s results shed an interesting light on Stone (2005) in that the latter’s results were based on a survey of the literature to determine the extent of subjects who had been diagnosed as having a psychiatric illness but whose symptoms had subsequently been found to be due to a physical illness. His results are of interest only if it assumed that a practice existed whereby subjects diagnosed as having a psychiatric illness, had ongoing medical examinations to an extent likely to uncover any organic illness. If, for example, a scenario such as depicted by Hall (1980) was common in modern psychiatric practice, then the likelihood of any underlying organic pathology being discovered which was causative of the psychiatric symptoms and then subsequently being reported in the medical journals, would be extremely low and Stone’s (2005) conclusion that the misdiagnosis of conversion symptoms has been at a consistently low rate of 4% for every decade since the 1970’s²⁷⁷ would run the risk of being a serious misrepresentation of the actual situation.

²⁷⁴ Hall (1980), p.989.

²⁷⁵ *Ibid.*

²⁷⁶ *Ibid.*

²⁷⁷ Stone (2005), p.4.

Yet in 2005, the CATIE²⁷⁸ trials uncovered a situation not dissimilar to that examined in Hall (1980); these trials were designed to determine the effectiveness of various antipsychotic drugs in actual clinical practice:

... [they were] financed by the US National Institute of Mental Health (NIMH) in 24 States at 57 sites on 1460 subjects with schizophrenia, at a cost of over US\$50m ...²⁷⁹

Hence the study is particularly authoritative. Bick (2007), commenting on the results of the trials, states:

The most stunning finding was that psychiatrists tend to ignore life-threatening, treatable medical conditions in patients presenting for treatment with schizophrenia. ... [the study] did expose a woeful standard in the medical management of schizophrenia offered by psychiatrists.²⁸⁰

Whilst the CATIE study made no findings in relation to conversion symptoms, it did eviscerate the 'default presumption' implicit in Stone's conclusion namely that subjects diagnosed as having a psychiatric illness, had ongoing medical examinations to an extent likely to uncover any organic illness. Stone's (2005) apparent unwillingness to make explicit and justify this presumption reinforces the earlier conclusion that research into psychiatric misdiagnosis appears to exhibit partiality.

There is an additional default presumption implicit in Stone's analysis namely that the inability of non-psychiatric medicine to find a physical cause for a subject's presenting symptoms, implies that the symptoms are psychiatric in origin. Per Dalén,²⁸¹ noting some of the illnesses which in earlier times were regarded as psychosomatic in origin (*e.g.* peptic ulcer, Lyme disease, electrosensitivity), is highly critical of such an approach:

As a psychiatrist, I have to say it is rather distressing to witness how unconcernedly certain colleagues are abusing psychiatry, allowing other interests than those of the patients to take precedence, even though they are not actually being forced to do so.²⁸²

... If the somatic doctors feel that they cannot find any explanation or accepted diagnosis in a given case, this certainly does not mean that the causes must necessarily be psychological.²⁸³

²⁷⁸ 'Clinical Antipsychotic Trials of Intervention Effectiveness' [CATIE].

The CATIE trials and results are reported in Lieberman (2005) and are discussed in Chapter 5.

²⁷⁹ Bick (2007), p.465.

²⁸⁰ *Ibid.*

²⁸¹ Per Dalén is Associate Professor of Psychiatry at the University of Göteborg, Sweden.

²⁸² An example of the '*non-purposeful misdiagnoses*' spoken of by Reich (1994) (*supra*).

²⁸³ 'Somatic medicine abuses psychiatry and neglects causal research.' [online], available: http://art-bin.com/art/dalen_en.html [accessed: 4 October 2008].

I have devoted a considerable space to discussing Stone (2005) in order to show how such a seemingly authoritative finding of low levels of psychiatric misdiagnosis, may serve to mask, and distort, a much more complex reality.

D.4: Towards a general estimate of the rate of psychiatric misdiagnosis

In that the rate of misdiagnosis in non-psychiatric medical practice in Ireland is in the region of 25% [see Appendix I], the problem of estimating rates of psychiatric misdiagnosis can be recast as one of determining whether the psychiatric misdiagnosis rate is less than, or exceeds, this medical non-psychiatric misdiagnosis rate of 25%.

It was concluded (*supra*) that a number of factors exist which render psychiatric diagnosis more prone to error than non-psychiatric diagnosis and in the absence of any identifiable countervailing forces, the conclusion may be drawn that the psychiatric misdiagnosis rate is, at least, 25%.

The extent of the misdiagnosis of physical illness as psychiatric illness – and in the absence of a converse phenomenon (*i.e.* the misdiagnosis of psychiatric illness as physical) of any comparable magnitude – supports the conclusion that the rate of psychiatric misdiagnosis exceeds that of non-psychiatric misdiagnosis.

The Precautionary Principle (*supra*) may, in the absence of conclusive evidence to the contrary, also be invoked in support of this conclusion.

Amongst the further indicators adding support to the conclusion just drawn are, for example:

1. Spitzer, interviewed²⁸⁴ in 2007, was questioned on the checklist system of diagnosis embodied in the *DSM* project of which he was the principle architect; the following is an excerpt from that interview:

Spitzer: What happened is that we made estimates of prevalence of mental disorders totally descriptively without considering that many of these conditions might be normal reactions which are not really disorders; that's that is [*sic*] the problem, because we were not actually looking at the context in which those conditions developed.

[Interviewer]: So you have effectively medicalised much of ordinary human sadness, fear, ordinary experiences, you've medicalised them?

Spitzer: I think we have to some extent, how serious a problem it is, is not known; I don't know if it is 20% or 30% I don't know, but that's that is [*sic*] a considerable amount if it is 20 or 30%.

²⁸⁴ See Curtis & Lambert (2007).

2. In a separate report²⁸⁵ Spitzer also cast doubt on the reliability of the diagnosis of attention deficit disorder and suggested that up to 30% of youngsters classified as suffering from disruptive and hyperactive conditions could have been misdiagnosed.²⁸⁶
3. The overdiagnosis of other psychiatric conditions such as, for example, depression²⁸⁷ and bipolar disorder have also been reported; in relation to the latter a study found that less than half those previously diagnosed with bipolar disorder actually met the diagnostic criteria for the diagnosis when assessed by a structured psychiatric clinical interview.²⁸⁸ The authors were particularly concerned at the level of misdiagnosis because of the seriousness of the side effects of the medication used in the treatment bipolar disorder.²⁸⁹

It should be noted that the misdiagnosis discussed in the above estimates did not focus on ‘technical’ psychiatric misdiagnosis *i.e.* the giving of an incorrect psychiatric diagnosis in place of an alternative, and correct one, but rather the more serious problem of diagnosing that a subject had a psychiatric illness when in fact they had none.

D.5: Towards an estimate of the rate of misdiagnosis of schizophrenia

The absence of data in relation to the extent of psychiatric misdiagnosis has been commented on earlier and one of the few areas where estimates have emerged is in relation to the misdiagnosis of schizophrenia. These estimates are not authoritative global estimates but rather the by-product of studies which had a narrower focus *e.g.* psychiatric misdiagnosis in relation to racial minorities. Some of these studies are mentioned below and indicate a schizophrenia misdiagnosis rate considerably in excess of 25% – an estimate which receives some indirect support from the results of a survey of UK psychiatrists²⁹⁰ (*supra*).

Various academic psychiatrists have expressed doubts as to the very coherence of the concept of schizophrenia; some such views are discussed below and provide a further indicator of the nature and extent of the misdiagnosis of schizophrenia.

²⁸⁵ Roberts, M. (2007). ‘No such thing as naughty anymore?’. *BBC News*. 14 March. [online], available: <http://news.bbc.co.uk/2/hi/health/6302209.stm> [accessed: 7 October 2008].

²⁸⁶ Coming from such an authoritative source, these comments reinforce the conclusion drawn in Chapter 3 that the psychiatric use of the terms ‘pathological’ and ‘normal’ is deeply flawed.

²⁸⁷ Houston, M. (2005). ‘Psychiatrist warns of overdiagnosing depression’. *The Irish Times*. 20 Sept: “UCC Lecture: ... Prof Patricia Casey will say she is concerned that about twice as many people as require them are being prescribed antidepressants.”

²⁸⁸ Zimmerman (2008) (*supra*).

²⁸⁹ See Chapter 5 in relation to the seriousness of the side effects of some psychoactive medications.

²⁹⁰ Kingdon (2004) (*supra*).

A 1978 study (based on data analysed prior to the publication of the *DSM-III*) stated:

We conclude that most so-called schizophrenic symptoms, taken alone and in cross section, have remarkably little, if any, demonstrated validity in determining diagnosis, prognosis, or treatment response in psychosis.²⁹¹

In 1988, after the introduction of *DSM-III*, the authors revisited their earlier conclusions:

[the] *DSM-III* in 1980 and *DSM III-R* in 1987 has widened the diagnosis of ... bipolar disorder and narrowed the domain of schizophrenia. Patients in American hospitals are now much less frequently diagnosed as schizophrenic and more frequently as bipolar: a valuable trend, considering the potentially grave consequences of being mislabeled as “*schizophrenic*.”²⁹²

This view received some confirmation from a 1983 study²⁹³ which found that 79% of a group of bipolar subjects had previously been misdiagnosed as schizophrenic.

Pope & Lipinski (1978) had expressed the hope that the implementation of the *DSM-III* had ameliorated the problem of psychiatric misdiagnosis, however, in view of the findings [Zimmerman (2008) *supra*] that over half of those who had been diagnosed with bipolar had been misdiagnosed, their optimism was clearly misplaced.

Pope & Lipinski (1978) concluded by speculating:

... that, over the next few decades, the term “schizophrenia” may come to have less and less meaning, and far less significance, as it describes an ever-smaller residual group of patients with various unrelated idiopathic chronic psychotic disorders. Only time can tell whether this third impression – an unpopular one, we fear, in many circles – will be justified.

Their suggestion that the concept of schizophrenia lacks coherence is a continuing topic of controversy²⁹⁴ and that fact alone suggests that, in the absence of its resolution, the misdiagnosis of schizophrenia will necessarily be a continuing problem.

Returning to the problem of seeking estimates for the rate of misdiagnosis of schizophrenia, a 1985 study²⁹⁵ found that 75% of the psychiatric diagnoses reviewed were suspect²⁹⁶ with the misdiagnosis of schizophrenia (in place of depression) being the most common. While originally 89 patients had been diagnosed as schizophrenic, that diagnosis was confirmed in only 16 cases. Commenting on this study, Lipinski –

²⁹¹ Pope & Lipinski (1978).

²⁹² *Ibid.*

²⁹³ Egeland (1983) (*supra*).

²⁹⁴ van Os & McKenna (2003).

²⁹⁵ Lipton & Simon (1985); see also a report by Goleman, D. (1985). ‘State hospital accused of wrong diagnoses, fueling debate over nation’s mental care.’ *The New York Times*. 23 April.

²⁹⁶ Goleman (1985): “*The drugs usually prescribed for schizophrenia are known as neuroleptics; ... Because neuroleptics have a powerful suppressive effect on a patient’s symptoms, they make a more accurate rediagnosis unlikely...*”

whose earlier study²⁹⁷ had reported that approximately 40% of patients diagnosed as schizophrenic did not have that disorder – believes the rate of misdiagnosis was still as high in 1985; he stated:

It's a very hotly debated issue,... Some people would like to pretend misdiagnosis has gone away. But it hasn't. And the human wreckage is outrageous."²⁹⁸

A 1995 study found that of a group of older patients being moved to a newly established geriatric centre; 67% of patients had been wrongly diagnosed with schizophrenia (in place of affective disorder); it concluded:

These results provide support for the hypothesis that older persons with psychiatric illness may have been misdiagnosed at a time of less diagnostic rigor.²⁹⁹

Hickling (1999) (*supra*) provided compelling evidence that the “*times of less diagnostic rigor*” which facilitated the misdiagnosis of schizophrenia, are not necessarily in the past. It provided compelling evidence of the continuing existence of high rates of misdiagnosis of schizophrenia.³⁰⁰

The authors compiled the following table:³⁰¹

<i>Diagnostic Method</i>	<i>All Patients (n=66)</i>	<i>White (n=24)</i>	<i>Afro-Caribbean (n= 29)</i>	<i>All Black (n= 42)</i>
<i>British psychiatrists</i>	36 (55%)	13 (54%)	18 (62%)	23 (55%)
<i>Jamaican psychiatrist</i>	32 (49%)	10 (42%)	16 (55%)	22 (52%)
<i>CATEGO</i> ³⁰²	43 (65%)	13 (54%)	21 (72%)	28 (67%)

Table 4-3: The diagnosis of schizophrenia by three different methods

This table provides eloquent testimony to the existence and prevalence of misdiagnosis in relation to schizophrenia but it tells only part of the story in that it provides aggregate figures; to appreciate the extent of the misdiagnosis it is necessary to examine individual cases. The figures in the following table were abstracted from the study³⁰³ and provide a more compelling representation of the misdiagnosis of schizophrenia in relation to particular individuals.

²⁹⁷ Pope & Lipinski (1978) (*supra*).

²⁹⁸ Goleman (1985) (*supra*).

²⁹⁹ Baker (1995).

³⁰⁰ See Sharpley (2001) (*supra*): “... *this study indicates that the routine clinical diagnosis of schizophrenia is not a reliable one, but provides no evidence that it is applied in a racially biased manner.*”

³⁰¹ Hickling (1999), p.284.

³⁰² A score generated from the *Present State Examination* (a check list used in psychiatric diagnosis).

³⁰³ They figures relate to Black patients, data for other patients was not in a form that permitted a similar abstraction.

<i>Subjects (n=42)</i>	<i>British psychiatrists</i>	<i>Jamaican psychiatrist</i>	<i>Present State Examination (PSE)</i>
1	Schizophrenic	Schizophrenic	Schizophrenic
2-15	"	"	"
16	Schizophrenic	Schizophrenic	Schizophrenic
17	Schizophrenic	No	Schizophrenic
18	Schizophrenic	No	Schizophrenic
19	Schizophrenic	No	Schizophrenic
20	Schizophrenic	No	Schizophrenic
21	Schizophrenic	No	Schizophrenic
22	Schizophrenic	No	Schizophrenic
23	Schizophrenic	No	Schizophrenic
24	No	Schizophrenic	Schizophrenic
25	No	Schizophrenic	Schizophrenic
26	No	Schizophrenic	Schizophrenic
27	No	Schizophrenic	Schizophrenic
28	No	Schizophrenic	Schizophrenic
29	No	Schizophrenic	No
30	No	No	No
31-41	"	"	"
42	No	No	No

Table 4-4: The diagnosis of schizophrenia in relation to 42 individual Black patients.

A further perspective on individual misdiagnosis may also be gleaned from the report:

Of the seven patients from the ‘disagreement’ group diagnosed as having schizophrenia by the British psychiatrists, three were diagnosed with mania, two with depression, and two were given no diagnosis by the Jamaican psychiatrist.³⁰⁴

Thus the misdiagnosis of schizophrenia occurred in cases where there is disagreement as to whether any mental illness is present.

The above discussion enables the conclusion to be drawn that the schizophrenia misdiagnosis rate is at least comparable to that of general psychiatric misdiagnosis *i.e.* in excess of 25%. The Precautionary Principle may, in the absence of conclusive evidence to the contrary, also be invoked in support of this conclusion.

Section E: Conclusions

Before discussing estimates of the rate of radical psychiatric misdiagnosis [*Subsection E.2*] a brief mention is made of the ethical responsibility of the psychiatric diagnostician [*Subsection E.1*].

³⁰⁴ Hickling (1999), p.284.

E.1: A note on the ethical responsibility of the psychiatric diagnostician

Witztum (1995b) (*supra*) argues that the problem of psychiatric misdiagnosis is not simply a technical one but is also of ethical importance; as described by his patient ‘A’:

... the various mental health professionals ... had failed to demonstrate ‘*professional integrity and personal courage*’ by discrediting the damaging psychiatric label attached to him, especially in the absence of supporting clinical evidence.³⁰⁵

In furtherance of this point, Witztum (1995b) quotes Reich (1999) (*supra*)³⁰⁶ concerning the particular ethical responsibilities that are placed on one making a psychiatric diagnosis as distinct from a medical diagnosis, in that the psychiatric diagnosis may entail not only loss of freedom but also lifelong stigma.

At first sight, it might seem that the act of medical diagnosis – and, by implication, psychiatric diagnosis – is akin to the act of seeing clearly that which others less skilled, are unable to discern. As such, and in the absence of bad faith or misrepresentation, the act of medical diagnosis would appear to be – if not unequivocally ‘a good’ – at least benign. Such a conclusion would be unwarranted because, as Reich argues, the consequences that may follow an erroneous or inappropriate psychiatric diagnosis are so momentous that the act of psychiatric diagnosis should be scrutinized from an ethical perspective rather than being perceived as being purely a technical question.

An analogy which is by no means perfect but which does allow Reich’s analysis to be more clearly understood, may assist: consider a physician working in South Africa under the apartheid laws and being requested to test a subject of mixed race, to determine whether the preponderance of their racial characteristics is ‘white’ or ‘coloured’. Seen from one perspective, the doctor is required to perform a purely technical test and, within that context, questions may be raised about the test’s reliability, its propensity to generate false positives *etc.*; seen from another perspective, the test results may have momentous consequences for the subject involved.³⁰⁷ Reich’s

³⁰⁵ Witztum (1995b), p 666.

³⁰⁶ *Op. cit.*, p 667:

Reich emphasized that ‘*it is the prerogative to diagnose that enables the psychiatrist to commit patients, against their will, to psychiatric hospitals, that delineates the populations subject to his care, and that sets in motion the methods he will use for treatment*’.

Regarding ‘*the actual or potential misapplication of diagnostic categories to persons who do not deserve or require them*’ he stresses ‘*the harmful effects of psychiatric diagnosis*’, which ‘*include not only the loss of personal freedom, and not only the subjection to noxious psychiatric environments and treatments, but also the possibility of life-long labeling as well as a variety of legal and social disadvantages*.’

³⁰⁷ Adding a further level of complexity enables the analogy to more closely mirror problems of psychiatric misdiagnosis [see, for example, Witztum (1995b) *supra*]:

point is that the ethical obligations of the physician are not simply limited to performing the test to the best of his technical ability but he is also required to be fully cognisant of the consequences that may flow from his decisions and, if he is to act ethically, he must always function within this wider context.

Conversely, a purely technical examination of the justification for coercive psychiatric interventions – *i.e.* one which limits itself to a consideration of the topics normally found within the covers of psychiatric textbooks – and which omits consideration of not only the (mathematical) risk of erroneously diagnosing a subject as being mentally ill but the likelihood of their suffering damage to their personhood (whether by loss of freedom or severe stigma),³⁰⁸ risks becoming in itself, a deeply unethical exercise in that by adopting an unduly narrow focus it necessarily precludes consideration of issues of overriding ethical importance.³⁰⁹

Some of the ethical problems peculiar to psychiatric diagnosis can also be approached from an examination of the principles that should underlie the choice of default presumptions – *i.e.* in whose favour (the psychiatrist or the subject) should a doubt be resolved? Some such principles have been proposed in earlier chapters.

A further point of considerable ethical importance, concerns the practice within psychiatry of regarding a subject's refusal to accept a psychiatric diagnosis [see 'denial' (*supra*)] as independent and additional confirmatory evidence of the subject being mentally ill. The prevalence of such practice severely militates against the acceptance by psychiatrists of even the possibility of psychiatric misdiagnosis which, in view of the findings earlier in this chapter is both an ethically, and professionally, untenable stance. An insight from a practitioner of another medical speciality not noted for their willingness to accept their fallibility, namely surgeons, is apposite:

When we have to fire one of our surgical trainees it is never because they don't have the physical skills but because they don't have the moral skills - to practise and admit failure.³¹⁰

Consider that the subject appeals the determination of race and that the appellate officer finds that the test used to determine race is inconclusive but refuses the appeal because, in cases of doubt, he does not wish to overrule a professional colleague.

³⁰⁸ Topics seldom adequately addressed by academic psychiatrists. [See Chapters 6 and 7].

³⁰⁹ See, for example, 'A's assessment of many of the psychiatrists who reviewed his case. [Witztum (1995b), *supra*].

³¹⁰ Laurance, J. (2011). 'Atul Gawande: a career built on an obsession with deadly failures'. *The Independent*. 25 April: "Gawande's message is that instead of denying our fallibility we need to embrace it and learn from it."

Atul Gawande is a surgeon and author.

E.2: Towards an estimate of the rate of radical misdiagnosis

Finding a general rate of psychiatric misdiagnosis does not necessarily imply that such a rate should apply to coercive psychiatric interventions. It may well be imagined that a far more rigorous standard would apply in such cases. Because the rate of coercive psychiatric interventions grounded in a misdiagnosis was not directly accessible,³¹¹ it is necessary to find some indirect method of estimation.

An examination of some of the journal search results³¹² suggest such a method by virtue of the observations:

- (i) that raised rates of involuntary committal were largely attributable to higher rates of schizophrenia,³¹³
- (ii) that the consequences of a misdiagnosis of schizophrenia in cases where it does not precipitate a coercive psychiatric intervention, are of a level of gravity altogether higher than those following a technical misdiagnosis and comparable to those following a wrongful coercive psychiatric intervention.³¹⁴

This suggests that the rate of misdiagnosis of schizophrenia may act as a surrogate for the rate of radical misdiagnosis.

The conclusion has been drawn [D.5 (*supra*)] that the rate of misdiagnosis of schizophrenia is in excess of 25%. This enables the conclusion to be drawn that the rate of radical misdiagnosis – *i.e.* the rate of coercive psychiatric interventions which were grounded in a psychiatric misdiagnosis (and which would not have occurred in the absence of this misdiagnosis) – should be taken as being in excess of 25%.

In the absence of conclusive evidence to the contrary, the Precautionary Principle may also be invoked in support of this conclusion.

The extremely wide variation in involuntary committal rates (four–fold within Ireland and fortyseven–fold within the EU)³¹⁵ provides eloquent testimony to the magnitude of the problem of radical misdiagnosis and lends support to estimates of a level of radical psychiatric misdiagnosis of an order of magnitude considerably in excess of 25%.

³¹¹ The objective in undertaking the journal searches (*supra*) was to find a definitive estimate of the prevalence of radical misdiagnosis. No such estimate was found.

³¹² Particularly the results of psychiatric journal searches for occurrences of both ‘*misdiagnosis*’ and ‘*compulsory admission*’.

³¹³ See, for example, Thomas (1993) (*supra*).

³¹⁴ See, for example, Kingdon (2004) (*supra*).

³¹⁵ See subsection D.2 *supra*.

Chapter 5: Problematic aspects of coercive psychiatric treatments¹

Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. ... those who torment us for our own good will torment us without end for they do so with the approval of their own conscience.

C.S. Lewis²

Note: The discussion of psychiatric treatments in this Chapter³ is not intended to provide a comprehensive, objective and balanced overview of current psychiatric treatments. Such a project lies far beyond not only that which is required to establish the dissertation argument but also the competence of the present writer. The goal of this Chapter is much more modest; it is to show that the presumption that psychiatric treatments are ethically unproblematic (in the sense of being securely grounded in evidence based studies and, and if not beneficial, then at least not harmful) cannot be assumed to be true. Adherence to such a presumption is implicit in the extreme unwillingness – if not outright refusal – of the Philosophy of Psychiatry⁴ to ‘cross the disciplinary threshold’ and include the iatrogenic effects of psychiatric treatments in the ethical analysis of coercive psychiatric intervention.⁵

In short, the goal of this Chapter is to establish a *prima facie* case that many psychiatric treatments are not only not well grounded in evidence based studies but may cause serious harm.

Ideally, the conclusion to this chapter would answer the question:

*What proportion of coercive psychiatric treatments are, on balance, harmful to those subjected to them?*⁶

¹ The psychiatric treatments that will be considered in this chapter are pharmaceutical; though other treatment are in use, some (such as psychosocial) are not amenable to coercive administration and others (such as ECT and psychosurgery) are, in comparison with pharmaceutical treatments, rarely used.

² From his essay *The Humanitarian Theory of Punishment* [See Lewis (1949)].

As an illustration of Lewis’ point, consider the report of the jurist George Annas writing in *The Lancet* on the use of force-feeding in Guantanamo Bay:

... the senior medical officer told reporters that he was “*extremely proud*” to be there, but refused to give his name. He described the process of force-feeding prisoners in restraint chairs as “*endearing*”, said the nasogastric tubes were “*gently inserted*”, and that *Ensure* was being supplied in three flavours: strawberry, butter pecan, and chocolate. [Annas (2009), p.1737]

The World Medical Association has prohibited doctors from participating in force-feeding. [See *Lancet* (2009)]

³ And in Appendices K (which discusses problematic aspects of antidepressant research) and L (which discusses problematic aspects of antipsychotic research).

⁴ And of the Irish legal system.

⁵ An ancillary goal is to assess the reliability of psychiatric assessments by examining whether psychiatric clinical treatment decisions are, or are believed to be, evidence-based.

⁶ This necessitates a supplemental question:

(i) How secure is the evidence base for the psychiatric treatments which are used coercively?

And three further questions (relevant to the general reliability of psychiatric assessments):

Before tackling this question, some perspective may be provided by examining medical (*i.e.* non-psychiatric) practice both as to the harm that may ensue from, and the evidence base for, general medical treatments.

In 2009, the Institute of Medicine reported on the evidence base for such treatments:

All too often, the information necessary to inform these medical decisions is incomplete or unavailable, resulting in more than half of the treatments delivered today without clear evidence of effectiveness.⁷

Estimates of the extent of iatrogenic harm⁸ occasioned by medical treatment are given in *Appendix I* and amongst the conclusions drawn are that, of all Irish hospital admissions:

- at least 3.7% are subjected to iatrogenic harm⁹;
- *c.* 25–50% suffer adverse drug reactions [ADRs];
- such ADRs are grossly underreported.

It is also concluded that, in the absence of robust evidence to the contrary, similar levels of harm should be assumed to occur in Irish psychiatric hospitals; it can be argued that such a conclusion is unduly conservative in view of firstly, the legal barriers¹⁰ facing anyone attempting to seek redress for negligent psychiatric treatment and secondly, the poor standards of governance and record keeping found in Irish psychiatric hospitals.¹¹

Note: Iatrogenic harm, in that it is unforeseen, can be distinguished from the so-called ‘side effects’¹² of psychiatric treatments which will be discussed later in this chapter.

The maxim ‘*Primum non nocere*’¹³ is one of the most important ethical principles governing the administration of medical treatment and has traditionally been interpreted

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- (ii) How aware are clinical psychiatrists of any deficiencies in the evidence base for psychiatric treatments which are used coercively?
 - (iii) Do the treatment decisions of clinical psychiatrists, accord with the known evidence base?
 - (iv) Do psychiatrists in their treatment decisions, manifest an awareness of the likelihood, and the severity, of the harm that may ensue from their proposed treatments?

⁷ Institute of Medicine (2009).

⁸ *I.e.* harm inadvertently caused by medical treatment.

The estimates given in Appendix I were based on the Institute of Medicine report *To Err is Human* [Institute of Medicine (1999)]. In 2011, it was reported that:

Over 10 years later, the problem of medical errors remains and might even have escalated. In the April issue of *Health Affairs*, David Classen reports that as many as one in three patients in the USA encounters a medical error during a hospital stay. [Lancet (2011)]

⁹ See also the discussion in the Introduction.

¹⁰ See Appendix A; the difficulty in commencing civil proceedings in respect of negligent psychiatric treatment, forecloses one of the main avenues for uncovering the extent of iatrogenic psychiatric harm.

¹¹ See, for example, MHC (2005), p.53: “*The lack of governance in both management systems and clinical systems within the mental health service is both evident and disturbing.*”

See also Walsh (1998) (*supra*).

¹² A ‘side effects’ is foreseen but unintended, ‘iatrogenic harm’ is unforeseen and unintended; the distinction parallels that made in describing the consequences of a military action as being either ‘collateral damage’ or ‘due to error’.

as simply implying that the benefits to the patient of any proposed treatment must outweigh the detriments. It will be argued [in Section A] that such an interpretation is outmoded:

- in general medicine, because it does not accord with a physician’s obligation to obtain a patient’s informed consent before commencing any treatment;
- in psychiatry, because now widely discredited treatments such as lobotomy, were once justified by means of such simple benefits/detriments or ‘best interests’ calculations. The appropriate response to such now reviled procedures, should not be simply a smug satisfaction comfortably content in the knowledge that these are now discredited practices of a bygone era, but should be to question the ethical principles which were used in their justification and to see how they may be reformulated to ensure that similar practices can never again occur.¹⁴

An alternative interpretation of the maxim will be offered which (in relation to non-coercive medical interventions) is in accord with modern doctrines of informed consent and which (in relation to coercive psychiatric interventions) would help to ensure that procedures such as lobotomy are irrevocably consigned to the bowels of history.

This alternative interpretation has different implications depending on whether the treatment is coercive or consensual and will enable the formulation of some ethical principles relevant to medical treatments given under coercion; in particular, it will imply that the belief (seemingly common amongst many psychiatrists) that the unalloyed intention to benefit the subject of the coercive treatment is, of itself, an adequate justification, is not sustainable.

Of the ethical principles identified two are of especial importance:

- (i) that the treatment must be grounded on evidence-based studies;
- (ii) that the decision to treat must be based *solely* (see *infra*) on the interests of the subject.

Sections B examines whether psychiatric clinical practice is in accord with the first principle and, if not, whether a definable ‘harm’ is visited on one subjected to such an

¹³ *I.e.* ‘First, do no harm.’

¹⁴ Compare the criticism by the philosopher Gillian Rose of Holocaust films such as Schindler’s list which, she states, degenerates into myth and sentimentality and “...*It leaves us ... piously joining the survivors putting stones on Schindler’s grave in Israel. It should leave us unsafe ...*”. She contrasts it with the work of Borowski which, she states:

... makes you witness the brutality in the most disturbing way for it is not clear from what position, ... as whom... you are reading. You emerge shaking in horror at yourself, with yourself in question.

Rose, G. ‘Beginnings of the Day – Fascism and representation’ in Cheyette & Marcus (eds.) (1998):242-256; at p. 242.

intervention; an analogous examination in relation to the second principle, is undertaken in Sections C.

A broad classification of the types of harms that may be occasioned by coercive psychiatric treatment is undertaken in Section D and the chapter's conclusions are summarised.

Some points of clarification: The acts of coercive treatment being discussed relate to sustained medical interventions and not, for example, to isolated acts of restraint such as are discussed in Chapter 1.¹⁵

Secondly, the grounds for consideration of coercive treatment are *solely* the interests of the subject and not the interests of others.¹⁶ The argument being developed at this point is the *Stage 1* argument; interventions justified partly on the interests of others [*Stage 2* and *3* arguments which incorporate issues of dangerousness] will be discussed in Chapter 6 and in the Conclusions.

Section A: Some ethical principles relevant to coercive treatment.

An example of a general medical treatment is discussed in Subsection A.1 and enables the ethical principles governing consensual and coercive treatment decisions to be distinguished and the application of these principles to decision making for consensual treatments to be discussed [Subsection A.2].

The application of the principles to coercive treatments is discussed in Subsection A.3 where some conclusions are also summarised.

A.1: An example from non-psychiatric medical practice.

In 2002 the *New England Journal of Medicine* published a study¹⁷ on the effectiveness of arthroscopic surgery as a treatment for osteoarthritis. The operation is performed on at least 225,000 Americans each year at a cost in excess of a billion dollars.¹⁸ The study compared the results of surgery with 'placebo surgery' where the patients were sedated whilst surgeons performed simulated surgery. The study concluded that "*the outcomes after arthroscopic lavage or arthroscopic débridement were no better than those after a placebo procedure.*"¹⁹

¹⁵ Where the examples given included that of a fireman stopping a father from entering a burning house to save his child and that of a climber who is suffering from altitude sickness, being forcibly brought down the mountain.

Such interventions were discussed in the Introduction and were termed '*quasi-coercive interventions*'; they will be discussed further in the Conclusions.

¹⁶ Hence the interventions in question would be similar to vaccinations undertaken in the interests of the subject rather than, for example, the forcible treatment of a carrier of infectious diseases (primarily undertaken in the interests of others).

¹⁷ Mosley (2002).

¹⁸ Kolata, G. (2002). 'Arthritis Surgery In Ailing Knees Is Cited as Sham.' *The New York Times*. July 11.

¹⁹ Mosley (2002), p.81.

The medical ethicist who helped design the study, stated "*Here we are doing all this surgery on people and it's all a sham.*"²⁰ An editorial accompanying the study wondered whether the procedure would be abandoned:

There's a pretty good-sized industry out there that is performing this surgery, ... It constitutes a good part of the livelihood of some orthopedic surgeons. That is a reality.²¹

A past president of the Academy of Orthopaedic Surgeons, casting doubt on the findings, said that the study's population was not typical of what he had seen in his private practice;²² other dissenting surgeons stressed the importance of clinical judgement.²³

In 2008, a second study was published [Kirkley (2008)] which added further weight to the contention that arthroscopic surgery was of little benefit; it compared the surgery with physical and medical treatments and found that: "*Arthroscopic surgery for osteoarthritis of the knee provides no additional benefit to optimized physical and medical therapy*".²⁴

In an attempt to determine the actual effects of these studies on clinical practice, one of the authors of the 2002 study was interviewed and commented:

What happened after our study was that organized orthopedics rallied the troops to try and discredit our study as much as possible ... People continued to practice the way they practiced.²⁵

In an editorial accompanying the publication of Kirkley (2008), the author of the earlier study commented that after its publication in 2002 the surgery "*became even more popular. ... It really didn't change practice, and they are doing a lot of it.*"²⁶

The reactions to these studies make clear the extreme confidence that many surgeons place in the validity of their clinical judgement even to the extent of allowing it to prevail over evidence-based studies; a disinterested observer might suspect that this confidence is a manifestation of professional and financial interests which (as will be seen later in this chapter)²⁷ are far from unknown in clinical psychiatry.

²⁰ Kolata (2002) (*supra*) quoting Dr. Baruch Brody.

²¹ *Ibid.*

²² *Ibid.*

²³ Ewing & Ewing (2002): "*The selection of patients is all important in arthroscopy. ... One could therefore predict, in advance of the study, the results that were obtained in a very elegant fashion.*"

²⁴ Kirkley (2008), p.1097.

²⁵ Kolata, G. (2008). 'A Study Revives a Debate on Arthritis Knee Surgery'. *The New York Times*. 10 September.

²⁶ *Ibid.*

²⁷ See also Appendix J.

A.2: Consensual and coercive treatment: differing ethical obligations

The maxim ‘*Primum non nocere*’ is discussed in [A.2.1](#). Some of the cognitive biases to which clinical judgement is particularly susceptible are discussed in [A.2.2](#); the importance of these biases can be minimised – at least, theoretically – in relation to consensual treatment [[A.2.3](#)] but such mechanisms are not available in relation to coercive treatment [[Subsection A.3 \(infra\)](#)].

A.2.1: The maxim ‘*Primum non nocere*’

As mentioned at the beginning of this Chapter this maxim has been widely understood by clinicians as meaning:

- ‘*Act in your patient’s best interests*’ or
- ‘*Act so that any harms occasioned by the treatment will be outweighed by its benefits*’.

I suggest that it is also capable of a different interpretation which, I argue, is more in accord with (in relation to consensual interventions) the doctrine of informed consent and with (in relation to coercive psychiatric interventions) the obligation on modern clinical psychiatrists to ensure that procedures such as lobotomy can never again occur under the guise of psychiatric treatment.

This maxim which is often translated as ‘*First, do no harm*’, is discussed by Markel (2004) who states that the closest that Hippocrates²⁸ came to enunciating this particular principle was in urging physicians: “*As to diseases, make a habit of two things — to help, or at least, to do no harm.*”²⁹

Stated thus, the principle falls into two parts:

- an injunction to help, and
- an injunction to do no harm.

The question then arises as to which of these injunctions should have priority: the first over the second³⁰ (the ‘permissive’ interpretation) or the second over the first (the ‘preclusive’ interpretation)?

Stated in such a fashion the problem is unduly polarised and requires a degree of refinement and nuance:

²⁸ To whom the principle is often credited under the title ‘*The Hippocratic Oath*’.

²⁹ Markel (2004), p.2026.

³⁰ The belief that the first principle should have priority over the second may be due to the all too common assumption that ‘help’ is necessarily beneficial; the C. S. Lewis quotation [see this Chapter heading *supra*] as well as Philippa Foot’s analysis [see Introduction] should be sufficient to counter any such belief.

(i) in stating that the injunction to help has priority it is not suggested that this should be interpreted as permitting a disregarding of any harms that may ensue but rather as requiring that the harms which may be occasioned by the treatment are judged to be outweighed by its benefits;

(ii) the statement that the injunction to do no harm has priority, should be understood subject to the following:

Firstly, the term ‘harm’ requires a gloss: transient harms [*i.e.* discomfort] need to be distinguished from more serious harms, the latter being those that, if long lasting, a psychiatrist would be unwilling to countenance in his own life unless offset by very substantial, and proven, benefits; these serious harms might be better described by the term ‘impairments’. The irreversibility of a harm is also relevant in assessing its seriousness; the default assumption being that it should be deemed to be serious unless the contrary is clearly shown.

Secondly, harms which are of such a nature as to be outweighed by the benefits of treatment, are defeasible.³¹

– (in the case of consensual treatment) by the consent of the subject;

– (in case of non-consensual treatment) by the consent of a court or by a prior consent of the subject (given when competent) by means of a power of attorney or an advance directive.

The following example may help indicate why the second interpretation should be preferred:

Imagine circumstances where a physician honestly believed that his intervention would help; imagine next that his intervention actually caused harm which he had not foreseen but – had he been more diligent in his analysis of possible harms and more alert to the possibility of their occurrence – could have been readily predicted. Could he be said to satisfy the principle?

I suggest not and that whilst he may have satisfied the principle when understood in its permissive sense, he did not satisfy the principle when understood in its preclusive sense (interpreted as an injunction to exert all diligence to ensure that harm is not a consequence of the intervention).

The application of the proposed interpretation of the maxim to consensual interventions [in Subsection A.2.3] will show that the proposed interpretation is in accord with current best medical (and legal) practice in that it *necessarily* requires adherence to the

³¹ Much as the obligation on an individual not to assault another is in some circumstances (*e.g.* in a sport such as boxing) defeasible by the prior consent of that other.

doctrine of informed consent; the traditional interpretation, in contrast, reflects a medical paternalism which was common in an age before the need for such doctrines was recognised.

The application of the proposed interpretation to coercive interventions is discussed in Subsection A.3 but first [Subsection A.2.2] it is necessary to briefly examine the susceptibility of clinical judgement to cognitive biases because it is from the recognition of the prevalence of such biases, that the necessity for evidence-based treatment decisions becomes paramount especially in relation to coercive treatment.

A.2.2: Susceptibility of clinical judgement to cognitive biases.

Kaptchuk (2003) discusses some of the cognitive biases to which medical practice is most susceptible; those most relevant to the present context are:

- *Rescue bias*: discounting data by finding selective faults in the experiment;
- *Auxiliary hypothesis bias*: introducing *ad hoc* modifications to imply that an unanticipated finding would have been otherwise had the experimental conditions been different;
- *Confirmation bias*:³² describes the tendency to seek and find confirmatory evidence in support of existing beliefs and to ignore or reinterpret disconfirmatory evidence.

It can be argued that the surgeons who dissented from the findings of the studies on arthroscopic surgery (*supra*) exhibited all of these biases.

The above list of biases is by no means exhaustive of those occurring in clinical medicine; Dowie & Elstein (1988), for example, emphasise the importance of the ‘*hindsight bias*’³³ especially in relation to the review of earlier diagnostic decisions.³⁴ However, of the biases of most relevance to an assessment of the reliability of clinical judgement, ‘confirmation bias’ is the most important.

Nickerson’s (1998) study of the confirmation bias begins with a quotation from the literature: “*Confirmation bias is perhaps the best known and most widely accepted notion of inferential error to come out of the literature on human reasoning.*”³⁵ and then turns to its definition:

³² See Chapter 3.

³³ *I.e.* viewed in hindsight, it seems as if the outcomes could not have been otherwise.

³⁴ *Op. cit.*, p.377: “*The presence of the bias suggests that individuals in this study tried to make sense out of what they knew had happened rather than analysing the available data independently.*”

³⁵ Evans (1989).

As the term is used ... generally by psychologists, confirmation bias connotes a less explicit, less consciously one-sided case-building process. It refers usually to unwitting selectivity in the acquisition and use of evidence.³⁶

Nickerson sees evidence of the operation of the bias in the multiplicity of treatments which are now discredited but which had previously been widely and uncritically accepted doubtlessly on the basis of clinical judgment:

It appears that people's beliefs about the efficacy of specific treatments were influenced more strongly by those instances in which treatment was followed by recovery than in either those in which it was not or those in which it occurred spontaneously.

Nickerson also notes that:

... despite the fact that clinical diagnoses based on case statistics tend to be more accurate than those based on clinical judgments, clinicians typically have greater confidence in their own judgments than in those derived statistically from incidence data.³⁷

The tendency to clinical overconfidence can, in general medicine, be tempered by the existence of definitive chemical, biological or neurological test results; in contrast, psychiatric overconfidence³⁸ is not chastened by any such requirement simply because such tests do not exist.

The existence of such cognitive biases normally preclude the clinician becoming consciously aware of his erroneous judgement; however it seems that even his becoming aware is no guarantee of his acknowledgement of the erroneous judgement. One commentator has used the term '*medical narcissists*' to refer to those clinicians who:

... find the disclosure of an error to be too much of a challenge to their self-image of competence, control and "treatment-oriented focus." Hence, they have a tendency to rationalize the error as unavoidable, unimportant, or unnecessary to reveal because it will not change the outcome.³⁹

A.2.3: Consensual treatment

A surgeon who, on the basis of his clinical judgement, recommends, for example, that a particular patient undergoes arthroscopic surgery, must – if the requisite consent is to be valid – fully inform the patient not only of the possibility of adverse effects (with their attendant probabilities) but also of studies which argue against the use of such a treatment. The consent – which is a legally necessary prerequisite for the surgery – is

³⁶ Nickerson (1998), p.175.

³⁷ *Ibid.*, p.189.

³⁸ See Appendix F.

³⁹ Rosenthal (2005).

an *informed* consent; a putative consent obtained in the absence of full objective information lacks validity.

Once the subject has received the information, he can exercise his own independent judgement. He can decide whether, based on his own experience, the clinician is worthy of his trust or he can seek further information or a second professional opinion. Finally, his giving or withholding of consent is determinative of whether or not the surgery proceeds.

If, in such a situation, the subject decides to proceed with the surgery then (being an autonomous adult) he has knowingly accepted the risk of harm. By assuming this risk of harm onto his own shoulders, he has discharged (in relation to that particular harm) the clinician's ethical obligations embodied in the maxim '*First, do no harm*' even if, in the particular circumstances, harm – and only harm – ensues. The situation is otherwise in coercive treatment.

In summary, in a setting where consent to treatment is required, no objection can be made to a clinician relying on his clinical judgement to:

- advocate a particular treatment even in the face of evidence-based studies which cast doubt on its efficacy, provided full and detailed information is provided; and,
- where informed consent is obtained, to administer the treatment.

A.3: *Coercive treatment*⁴⁰

The following questions fall to be discussed:

- (i) Can coercive psychiatric treatment decisions be based on a clinical judgment which conflicts with evidence-based studies?
- (ii) In the absence of relevant evidence-based studies, is it ever permissible to base coercive psychiatric treatment decisions solely on clinical judgment?
- (iii) Is the intent to act in a subject's best interests a sufficient justification for the coercive administration of treatment?

In making coercive treatment decisions – in contrast to consensual treatment decisions (*supra*) – the psychiatrist's obligation to 'do no harm' clearly cannot be discharged *via* the mechanism of obtaining a subject's informed consent, hence the psychiatrist's obligation to do no harm has an heightened importance; this requires a re-examination of the roles appropriate to clinical judgement and to evidence-based studies in the making of coercive treatment decisions.

⁴⁰ In circumstances where a coercive intervention *simpliciter* is justified on the grounds of, for example, dangerousness to others; though such circumstances may justify confinement they may not necessarily justify coercive treatment (see *infra*).

The role of clinical judgement in coercive treatment decisions is discussed in [A.3.1](#); the psychiatric assessment of ‘harm’, in [A.3.2](#) and the use of ‘best interests’ as a justification for coercive treatment, in [A.3.3](#). Some conclusions are drawn in [A.3.4](#).

A.3.1: Clinical judgement in relation to coercive treatment

The injunction ‘*do no harm*’ does not mean ‘*do not intend to do harm*’, still less does it mean ‘*hope to do no harm*’; hence implicit in the injunction is a further injunction to become as fully cognisant as is possible of the potential harms that may result from the treatment being proposed. The susceptibility of clinical judgement to cognitive biases has been discussed above and it is in the nature of such biases that the likelihood of harm will be minimised if not ignored and, correspondingly, the likelihood of success will be enhanced; hence, in all but the most exceptional circumstances⁴¹ unalloyed clinical judgement is not an adequate mechanism for adjudging that a proposed treatment will not occasion harm.

There is a further reason for disallowing the use of unalloyed clinical judgement which is of singular relevance to the practice of coercive psychiatry, namely that the clinical psychiatric assessment of what constitutes ‘harm’ to a subject in the context of psychiatric treatment, is – as is shown in the following examples (and later in this chapter) – particularly unreliable. In Ireland, the lack of effective judicial oversight and effective access to the courts, are possible reasons for such continuing lack of sensitivity.⁴²

A.3.2: The psychiatric assessment of ‘harm’: some examples

In discussing the Manweiler case,⁴³ the question was raised as to whether his being coercively medicated with antipsychotics could be more accurately described as a ‘damage’ rather than as a ‘treatment’.⁴⁴ Manweiler had been wrongfully medicated for ten years to the extent that he described himself as frequently “*feeling like a zombie*”,⁴⁵ yet in an extended discussion⁴⁶ of the legal judgement by some eminent Irish

⁴¹ Such as, for example, the use by Oliver Sachs of L-dopa as a treatment for sleeping sickness as described in his book *Awakenings* [Sachs (1983)].

In such exceptional situations where evidence-based studies are unavailable, the approval of a court should be a minimum requirement; as to the advisability of such a requirement see, for example, *Starson v Swayze* (2003) (*infra*).

⁴² See Introduction and Appendix A.

⁴³ See Appendix H.

⁴⁴ The term ‘treatment’ – in contrast to, say, ‘punishment’ – connotes a benefit rather than a detriment.

⁴⁵ Browne, V. (2005a). ‘False imprisonment: The story of John Manweiler’. *The Village*. 5 May.

⁴⁶ Excerpts are given in Appendix H.

psychiatrists, they were quite sanguine about any harm that had been visited upon Manweiler. Similar observations can be made in relation to the Juklerød case.⁴⁷

In times past some eminent psychiatrists have – without any suggestion of disapproval – made explicit the equation of psychiatric treatment with ‘damage’;

Sullivan (1964) in describing the effects of ECT and lobotomy, stated:

... [the patients] are reduced in human capabilities and drop back from a world the complexities of which provoked some insoluble conflict of adaptive impulses to one simpler and within the range of their surviving human abilities. Mental disorder is thus rectified by acquiring a mental defect, ...⁴⁸

Walter Freeman, famous for pioneering the use of lobotomies, stated:

The greater the damage, the more likely the remission of psychotic symptoms ... Maybe it will be shown that a mentally ill patient can think more clearly and more constructively with less brain in operation.⁴⁹

To the suggestion that lobotomized patients had “*lost their souls*”, Freeman responded:

Even if a patient is no longer able to paint pictures, write poetry, or compose music, he is, on the other hand, no longer ashamed to fetch and carry, to wait on tables or make beds or empty cans.⁵⁰

A 2003 Canadian case⁵¹ provides a good illustration not only of ‘treatment’ as ‘damage’ and lack of sensitivity by psychiatrists to possible harm but also of the poor reliability of psychiatric clinical judgement. The details of the case are outlined by O’Neill (2005):

... an exceptionally intelligent scientist who suffered from bi-polar disorder was detained in a psychiatric hospital after having been found not criminally responsible because of his mental disorder of uttering death threats.⁵²

Two psychiatrists decided to treat him with various psychoactive medications including antipsychotics. Under Canadian law, the subject [a Professor Starson] had the right to challenge this decision in the courts. After numerous appeals the matter finally reached the Ontario Court of Appeal which, in upholding the patient’s right to refuse treatment, stated:

The patient recognised he had psychiatric problems. The appellants however, could adduce no evidence to the effect that any of the many psychiatric medications forced on the patient in the past had ever helped him.
... at the root of the patient’s refusal was the effect of the medication on his scientific work. He found that the medication would slow his brain to the point where he could not pursue the thing which gave his life meaning namely his scientific research.⁵³

⁴⁷ See Appendix G.

⁴⁸ *Op. cit.*, p.171. [Emphasis and explanatory brackets in original].

⁴⁹ Quoted in Corry, M. (2008). ‘Barbaric age of electric shock ‘cure’ must vanish’. *The Irish Times*. 25 June.

⁵⁰ Eisenberg (1998).

⁵¹ *Starson v Swayze* (2003).

⁵² *Op. cit.*, p.268.

⁵³ *Ibid.*, p.269.

The psychiatrists appealed to the Canadian Supreme Court which, in rejecting the appeal, held that:

There was no evidence that the proposed medication was likely to ameliorate Professor Starson's condition. ... Dr. Posner noted that in general, only 60 percent of patients treated with neuroleptics respond favourably to new treatment. The evidence does not suggest that Professor Starson would fall into that category. He stated that medication attempts "*have always been the most horrible experiences of my life*".⁵⁴

The evidence indicates that the dulling effects of medication transformed Professor Starson "*into a struggling-to-think 'drunk'*", a result that precluded him from pursuing scientific research.⁵⁵

The court adopted the findings of an earlier case that neuroleptic medication carries with it: "... *significant, and often unpredictable, short term and long term risks of harmful side effects*".⁵⁶

The incongruence between the psychiatrists' beliefs and the court's findings is stark; the hubris displayed by the psychiatrists was only made manifest by virtue of it being possible under Canadian law to subject psychiatric treatment decisions to extensive forensic scrutiny – a seeming impossibility under current Irish Law.⁵⁷

A.3.3: 'Best interests' — a justification for coercive treatment?

Some eminent modern psychiatrists have defended the use in an earlier era, of now discredited psychiatric treatments such as lobotomy and colectomies⁵⁸ on the grounds either that the treatments were the only treatments available at the time or that the psychiatrists in question were acting solely in the best interests of their patients, thus implying the adequacy of such defences.

The use and defence of lobotomy is discussed in [A.3.3.1](#); and of colectomy, in [A.3.3.2](#). The adequacy of the proposed defences is discussed in [A.3.3.3](#).

It is important to note that knowledge of the deleterious consequences of both lobotomy⁵⁹ and colectomy⁶⁰ was available when the procedures were in general use.

⁵⁴ *Starson v Swayze* (2003), Para. 98; [Emphasis in original].

⁵⁵ *Ibid.*, Para. 102.

⁵⁶ *Ibid.*, Para. 101.

⁵⁷ See Appendix A.

⁵⁸ The removal of the colon. [See Scull (2005), p.51].

⁵⁹ Tranøy & Blomberg (2005):

Mortality was especially high in the early years: 18 of the first 35 lobotomies on women resulted in death. ... There is no reason to doubt that Norway's medical and public health authorities were aware of this high mortality rate. (p.109).

Tranøy (1996):

... Neither can ignorance of damaging effects be used as a justification since such effects were discussed very early in the development of the surgery. Finally, the patient's own suffering did not seem to be a significant factor. Rather, lobotomy seems to have been primarily a way of controlling troublesome patients ...

A.3.3.1: Lobotomy

The psychiatrist Raj Persaud⁶¹ begins his review of a book⁶² on Walter Freeman, thus: “*Aside from the Nazi doctor Josef Mengele, the US neurosurgeon Walter Freeman ranks as the most scorned physician of the 20th century.*” The review, however, concludes with the assessment that:

This extremely sympathetic account of Walter Freeman reminds us that doctors have, at the very least, courage in such attempts to engage with difficult and dangerous conditions – which the popular media, in their rush to condemn, fail to appreciate.⁶³

The lobotomy which had been popularised by Freeman, had been developed by Egas Moniz, a Portuguese neurologist for which he had been awarded the Nobel Prize in 1949. Recognising the harm occasioned by lobotomy, the Norwegian government has offered compensation to survivors of the operation and there have been calls for the revocation of the Nobel Prize.⁶⁴ However Bengt Jansson, Professor of Psychiatry at Karolinska Institutet in Sweden, believes that such calls are inappropriate:

At that time there did not exist any effective treatment whatsoever for schizophrenia, and the leukotomy⁶⁵ managed at least to make life more endurable for the patients and their surroundings. ... However, I see no reason for indignation ... as at that time there were no other alternatives! ... Actually, I think there is no doubt that Moniz deserved the Nobel Prize.⁶⁶

Jansson’s statement merits some comment:

- (i) his contention that the operation “*managed at least to make life more endurable for the patients and their surroundings*” is difficult to reconcile with firstly, a mortality rate in excess of 50% in the early years and secondly, with the awarding of compensation by the Norwegian Parliament in 1996, to survivors of lobotomy;⁶⁷
- (ii) his conflation of the patient’s interests with the smooth running of a hospital (“*more endurable for the patients and their surroundings*”)⁶⁸ also deserves criticism.
- (iii) his plea that, “*at that time there were no other alternatives*” can be a defence only if a universal medical duty to act – *i.e.* a ‘therapeutic imperative’⁶⁹ – exists; as pointed

⁶⁰ See Freeman (2005) *supra*.

⁶¹ Raj Persaud is Senior Lecturer in Psychiatry at the University of London and Gresham Professor for the Public Understanding Of Psychiatry.

⁶² El-Hai (2005).

⁶³ Persaud (2005).

⁶⁴ Goldbeck-Wood (1996).

⁶⁵ *I.e.* lobotomy.

⁶⁶ Jansson (1998).

⁶⁷ See Tranøy & Blomberg (2005) *supra*.

⁶⁸ [Emphasis added]. See also Tranøy (1996) *supra*: “*Finally, the patient’s own suffering did not seem to be a significant factor. Rather, lobotomy seems to have been primarily a way of controlling troublesome patients.*”

⁶⁹ See, for example, Paul (2004).

out earlier and despite urgings to the contrary⁷⁰ – there is no such medical duty ‘to act’.

A.3.3.2: *Colectomies*

The psychiatrist Hugh Freeman, in reviewing Scull (2005), summarised its conclusions regarding the psychiatric use of colectomies: Cotton who was the surgeon responsible for the development of the procedure, had reported that 85% of his cases had recovered. However, despite an independent review which found a post-operative mortality of 45%, the procedure was not stopped. Freeman, however, concludes that:

Cotton was not, in fact, a sadistic monster; he simply believed that everything he did was for his patients' benefit. ... Any objections from patients or relatives were brushed aside.⁷¹

A.3.3.3: *Inadequacy of the defences*

The goal of the above discussion was not to revisit the debate concerning now discredited psychiatric treatments but rather to see how, when modern psychiatrists comment on the probity of using such treatments, ‘good intentions’ or ‘lack of alternatives’ are regarded as exculpatory. The belief common to these (modern) psychiatrists, is that the unalloyed intention to benefit the subject is, of itself, an adequate justification for a coercive treatment. If the proposed interpretation (A.2.1 *supra*) of the maxim ‘*Primum non nocere*’ is correct then this belief is mistaken. Under such an interpretation, the primary obligation placed on a psychiatrist by the injunction ‘*Primum non nocere*’ is to do no harm; if the psychiatrist is not “well-nigh certain”⁷² that harm [‘impairment’]⁷³ will not ensue then he must desist from the intervention.⁷⁴ His belief that the probable benefit will outweigh the harm is not sufficient; neither is his belief that he is acting in the best interests of his patient; neither is his belief that he has ‘no other option’.

⁷⁰ See, for example, ter Meulen (2005) (*supra*) and his suggestion that: “... *in clinical practice there is a duty to act. Physicians have an obligation to do good to their patients ...*”

⁷¹ Freeman (2005) *supra*.

⁷² The phrase “well-nigh certain” is intended to describe circumstances where not only is it the belief of the vast majority of clinicians that such an intervention will not cause impairment but that no (minority) school of clinicians exists, which argues that it would cause impairment. Thus, for example, whilst the majority of clinical psychiatrists might believe that the use of ECT causes no impairment; a minority (see *infra*) believe that it does; accordingly it could not be said of ECT that it is “well-nigh certain” that it does not cause impairment.

⁷³ See gloss on ‘harm’ (*supra*).

⁷⁴ It will be proposed (*infra*) that in such circumstances the psychiatrist can appeal to the courts for permission to proceed with the intervention under the supervision of the court; appeal can also be made to an advance directive or to a representative with a power of attorney if such have been put in place.

A.3.4: A summary of some ethical principles governing coercive psychiatric interventions

I wish to summarise the above discussion in the light of the reinterpretation of the maxim '*Primum non nocere*' proposed earlier:

(i) The primary obligation placed on a psychiatrist, by the principle '*Primum non nocere*' is to do no harm.⁷⁵ In relation to a proposed coercive treatment, this obligation implies that the psychiatrist must be well-nigh certain that the proposed treatment will not entail any impairment. In the absence of this criterion being satisfied, the psychiatrist must desist from the contemplated intervention.⁷⁶

However, the principle '*Primum non nocere*' is an ethical obligation placed on the shoulders of the clinical psychiatrist by virtue of his role as a medical practitioner and – much like the obligation to do no harm could be discharged by the subject in the case of a consensual intervention, taking the burden onto their own shoulders – can also be discharged by the psychiatrist seeking the permission of the courts to proceed with the intervention.

(ii) In relation to coercive psychiatric treatments, the requirement that a proposed treatment does not occasion impairment must be discharged,⁷⁷ not by means of unalloyed clinical judgement, but on the basis of evidence-based studies; a similar requirement applies to the evidence of benefit.

A third conclusion flows from the intrusiveness occasioned by psychiatric treatment:

(iii) Because a coercive psychiatric treatment involves a trespass on the autonomy and dignity of the subject additional to that involved in a coercive psychiatric detention, it requires an additional justification; this is so even in circumstances where firstly, the 'no harm' criterion is satisfied and secondly, there is clear evidence of benefit.

This last conclusion is included to emphasise that a detention which is justified in the interests of others [the *Stage 2* and *3* arguments], does not necessarily imply the permissibility of coercive treatment. The discussion in Chapter 6 *infra* on the coercive treatment of those adjudged dangerous to others focuses, in part, on the attitude adopted by medical (non-psychiatric) practitioners to those – such as sex offenders or those suffering from infectious tuberculosis – who present a danger to others. Whilst the

⁷⁵ Harm in the sense of impairment (see *supra*).

⁷⁶ In particular, the clinical assessment that a proposed coercive psychiatric treatment is in the 'best interests' of a subject, or that the anticipated benefits outweigh the detriments, or that no alternative treatment is available, are not sufficient to discharge the obligation to do no harm.

⁷⁷ In all but the most exceptional circumstances [see *supra*].

medical practitioners might in certain cases sanction a coercive intervention such as detention, they exhibit a grave reluctance to coercively administer treatment. It is convenient for the purposes of furthering the discussion in *Section B (infra)*, to anticipate one of the conclusions to be drawn in Chapter 6 which is to the effect that:

Whereas a coercive psychiatric intervention (*e.g.* detention or restraint) may, in some circumstances, be justified by the interests of others, these interests do not justify additional coercive measures under the guise of psychiatric ‘treatment’.

If the coercive administration of psychiatric treatment to a subject whose detention or restraint is justified by the interests of others cannot be justified by an appeal to these same interests,⁷⁸ then *a fortiori* the interests of others cannot justify the coercive administration of psychiatric treatment to a subject detained or restrained in his own interests. This leads to the fourth conclusion:

(iv) A decision to coercively administer psychiatric treatment must not be influenced by assessments of the interests of others, but must be grounded *solely* on an assessment of the interests of the subject.

Section B: Current psychiatric practice and the Section A principles: a reliance on evidence-based studies?

Although, in theory it is possible to determine how closely everyday clinical psychiatric practice embodies the ethical principles outlined in Section A, in practice it is difficult if not impossible: in Ireland, for example, the poor standard of record keeping in relation to psychiatric treatment decisions⁷⁹ precludes any retrospective assessment as to whether these decisions were in accord with evidence-based practice; and whereas in other countries clinical record keeping in relation to coercive psychiatric treatments may be of such a standard as to permit such retrospective audits, these – as is discussed in *Subsection B.1* – are not only rare but also of limited value.

A feature underlying the presumed usefulness of such audits is the presumption that published studies which purport to be evidence-based, are in fact so – *i.e.* that they are methodologically sound, objective studies untainted by financial, or other, interests and fully reflective of the experimental evidence uncovered during the study. Such a presumption is often unjustified [*Subsection B.2*],⁸⁰ and this considerably complicates

⁷⁸ The medical obligation to ‘*do no harm*’ has been invoked against medical doctors and mental health professionals working at the Guantánamo Bay prison who failed to document medical evidence of the intentional harm of nine detainees. See Iacopino (2011).

⁷⁹ See *supra* MHC (2005) and Walsh (1998).

⁸⁰ See also Appendices P, K and L.

the task of assessing the level of psychiatric treatment decisions which are soundly based on an objective assessment of all available experimental and clinical data.

B.1: To what extent are coercive psychiatric treatment decisions grounded in evidence-based studies

Having posed the question “*Is psychiatric treatment evidence-based?*”, Summers & Kehoe (1996) begin their discussion by stating: “*We know of no published study of the extent to which psychiatric interventions are evidence-based.*”⁸¹ The authors report the findings of a 6 week study of 160 treatment decisions relating to 158 subjects and conclude that:

Evidence was identified to support 85 (53%) interventions. The most frequent were specific drug treatments for depression (n=35) and psychotic symptoms (n=10). ... We relied on authoritative reviews and well known evidence for our evidence of treatment effectiveness.

The weakness of the conclusion – *i.e.* that “*evidence was identified*” – in addition to:

- the authors’ belief that the figure of 53% is an overestimate,⁸²
- the fact that the identity and status of the “*authoritative reviews and well known evidence*” were undocumented by Summers & Kehoe (1996),
- the extremely limited nature of the study,
- the doubts that have been cast on the reliability of many of the studies which supposedly validated the use of antidepressant and antipsychotic drug treatments (*infra*, Appendices K and L),

amount to a less than ringing endorsement of the robustness of an evidence base supporting psychiatric treatment decisions.

A similar question to that of Summers & Kehoe (1996) was posed in Geddes (1996) but this study is similarly limited both in scope⁸³ and methodology;⁸⁴ Geddes (1996) begins by citing an estimate that only 10-20% of all medical interventions are evidence-based, however he argues that the assessment of the ‘proportion of interventions’ is not apposite and that “... *it is more meaningful to estimate the proportion of patients in common clinical situations who receive interventions based on evidence.*”⁸⁵

⁸¹ *Op. cit.*, p.409.

⁸² *Ibid.*, p.410: “*It is likely that we overestimated the extent to which evidence underpins clinical management ...*”

⁸³ The study was limited to an analysis of the treatments given to 40 patients admitted to an adult general psychiatric ward over a 28 day period.

⁸⁴ *Op. cit.*, p.215: “... [The lead author] *was responsible for the care of all but two patients included in the study, although treatment was often initiated by doctors who were not consultants.*”

⁸⁵ *Ibid.*

Utilising such a measure, he cites a study to the effect that in general medicine “... *over 50% of patients receive treatment based on evidence from randomised controlled trials.*”⁸⁶ – a level that Geddes (1996) concludes is similar to that which his study had found in psychiatry: “... *with patients as the denominator, most primary medical interventions given to psychiatric inpatients are based on evidence.*”⁸⁷ The weight to be accorded this finding is considerably diminished in view of his closing remarks:

However, we cannot conclude that there is systematically reviewed and readily available evidence for most psychiatric interventions. The evidence was difficult to find and we only found two usable systematic reviews of randomised controlled trials. ... There is also an urgent need for systematic reviews of the randomised controlled trials ... which have been undertaken.⁸⁸

A further study [Geddes & Wessely (2000b)] – in the course of its examination of the justification for the “*plethora of clinical practice guidelines ... that have been showered on psychiatrists ... over the last decade*”⁸⁹ – notes that, in relation to most psychiatric treatments:

We are often reasonably sure that a treatment offers some overall benefit, on average. But we are less certain that the treatment should always be used for all patients. ... There is no shortage of evidence in psychiatry. ... However, the quality of the existing evidence is often poor and the primary studies are disorganised.⁹⁰

Deficiencies in the evidence base for standard psychiatric treatments can also be gleaned from studies which had a more indirect focus: Currier & Allen (2000), for example, state:

The most common medication strategy in psychiatric emergency settings is the use of haloperidol and lorazepam in combination. ... Although this practice is generally regarded as safe and effective, the evidence supporting it is remarkably thin, with only two randomized, controlled studies totalling 118 subjects.⁹¹

Underlying the previous discussion is the belief that specific pharmacological treatments are used to treat specific disorders, however the truth of any such belief is seriously undermined by an observation made by Phillips (2010). Phillips who is Clinical Professor of Psychiatry at Yale, states:

The list of problems with the DSM-IV is well known. They include the significant degree of comorbidity among patients, the related problem of poor separation among DSM-IV disorders ... as well as the poor separation of disorder

⁸⁶ *Ibid.*

⁸⁷ *Op. cit.*, p.217.

⁸⁸ *Ibid.*

⁸⁹ *Op. cit.*, p.83.

⁹⁰ *Ibid.*

⁹¹ *Op. cit.*, p.719.

from normality, the dramatic non-specificity of pharmacologic agents in treating the various disorders ... our current practice of using just about every class of psychotropic to treat just about every class of disorder.⁹²

The final comment is a damning indictment of attempts to portray modern psychiatry as a rigorous scientific discipline.

Given that sound and conclusive evidence in relation to psychiatric treatments is sparse, the question arises as to whether clinical psychiatrists act in accordance with it on those occasions when it does exist. It seems that even the existence of sound evidence that a particular psychiatric treatment is efficacious and safe, is no guarantee of its use. No less authoritative a source than a Past President of the American Psychiatric Association, has stated:

Most psychiatrists with whom I've talked agree in principle with the approaches for which there is an evidence base, but few actually use them or prescribe their use.⁹³

The treatments to which Sharfstein refers are, in the main, psychosocial treatments and he suggests that the reason for abjuring such therapies in favour of pharmaceutical treatments lies in the excessive influence wielded by the pharmaceutical companies over professional psychiatry.⁹⁴ His analysis echoes that of Wiggins & Schwartz (1999) (*supra*) who spoke of the “*elective affinity*” that exists between the profession of psychiatry and the pharmaceutical industry, an affinity which is mutually beneficial. The benefits to the pharmaceutical industry are self-evident; the benefits accruing to psychiatry are more indirect: by cleaving closely to a manifestly science based industry, psychiatry absorbs – as if by a process of osmosis – some of the prestige of science; furthermore, the alignment of the psychiatric profession with pharmaceutical treatments helps differentiate clinical psychiatry from clinical psychology in that only⁹⁵

⁹² *Op. cit.*, p.10.

⁹³ Sharfstein (2006), p.3.

⁹⁴ Sharfstein (2005) touched on some of the reasons why this might be so:

We do not ensure quality in our own ranks. Our system of self-discipline is erratic, inconsistent, and also not in the public interest. We allow an unacceptable rate of medical errors in our practice, even as we campaign for tort reform. We have let the biopsychosocial model become the bio-bio-bio model.

... While there are many ethical areas for improvement, let me briefly mention the topical issue of the relationship between psychiatrists and the pharmaceutical companies. It is my view that these relationships have been rife with the appearance of conflict of interest and frankly with conflict of interest itself.

⁹⁵ By virtue of their training as medical doctors; there are, however, proposals in some US States, to permit prescribing by psychologists; see, for example, Pies (2010a): “*Otherwise* [GR: *i.e.* unless vetoed] *Oregon will become the third state in the country – along with New Mexico and Louisiana – to grant “prescribing privileges” to specially-trained psychologists.*”

psychiatrists have the right to prescribe pharmaceutical treatments.⁹⁶ The excessive influence of the pharmaceutical industry on both clinical and research psychiatry, lies at the heart of much of the criticism levelled against supposedly sound evidence-based studies of psychiatric treatments and will be discussed below.

It should be noted that the risk of harm occasioned by psychotherapeutic treatment is considerably less than that⁹⁷ caused by pharmaceutical treatment,⁹⁸ hence if – as suggested in Section A – the primary obligation in coercively treating a subject is to refrain from causing harm, then psychotherapeutic treatments should clearly be the treatment of first preference.

B.2: Deficiencies in supposedly sound evidence-based studies of psychiatric treatments

In assessing research on pharmaceutical treatments, randomised placebo-controlled, double blind studies are said to constitute the ‘gold-standard’.⁹⁹ Such a methodology is, however, open to objections some of which are practical, some theoretical and some ethical;¹⁰⁰ the practical and theoretical – being the most relevant in the present context – will be discussed in *Subsection B.2.1*.

Some studies which apparently met the ‘gold-standard’ of reliability, have subsequently been shown to have been compromised by virtue of the financial influence of the pharmaceutical industry; the distorting effect of such influence is discussed in *Appendix J*.

Two of the commonest psychiatric pharmaceutical treatments are antidepressants and antipsychotics; the later being of especial importance in relation to coercive psychiatry in that it is commonly used in the treatment of schizophrenia¹⁰¹ which (as discussed

⁹⁶ Sharfstein (2005) also noted that psychiatrists : “... [expressed] concern about the threat of prescribing by psychologists.”

See also an editorial in the British Journal of Psychiatry [Eisenberg (2000), p.1]:

Psychiatrists found it useful to emphasise their medical identity for purely economic reasons.

Prescribing drugs and monitoring drug therapy require a medical licence, whereas psychologists, social workers and counsellors can compete in the psychotherapy market in the USA.

Mindlessness had begun to replace brainlessness.

⁹⁷ Under the rubric of ‘side-effect’.

⁹⁸ See *infra*.

⁹⁹ See, for example, Miller (2000), p.716: “The placebo-controlled trial is widely regarded as the gold standard for testing the efficacy of new treatments.”

¹⁰⁰ For example, Miller (2000); the use of placebo controlled trials in situations where there is a proven treatment for a particular condition but where it is sought to determine whether a proposed treatment is also effective, would require the withholding of the proven treatment and the administration of a placebo [see also Cipriani (2009)].

See also Horng & Miller (2002): “... clinical trials of surgery have seldom included placebo surgery as a control, owing to ethical concerns.”

¹⁰¹ Geddes (2000a), p.1371:

earlier¹⁰²) can function as a surrogate for those psychiatric conditions precipitating coercive intervention.

Meta-analyses¹⁰³ of research on antidepressants is discussed in *Appendix K*, and of antipsychotics, in *Appendix L*. A summary of the conclusions drawn in these appendices is given in *Subsection B.2.2*.

A foretaste of the soundness of the research standards relied on in support of commonly used psychiatric pharmaceutical treatments, is given by Parikh (2009):

Even psychiatrists can sing the blues. Not just because of the current economic depression, but because of recent research findings. A series of pivotal effectiveness studies, in psychiatry—STAR*D, CATIE, and STEP.BD—have compared real-world performance of various treatments in depression, schizophrenia, and bipolar disorder. STAR*D showed that virtually all antidepressant strategies had low and similar efficacy in major depression. CATIE showed low effectiveness and similar comparability of antipsychotics. And STEP.BD showed that antidepressants are not effective for bipolar depression.¹⁰⁴

Some of the studies cited by Parikh (2009) are discussed *infra* and in Appendices K and L.

B.2.1: Some criticisms of the use of placebo-controlled, double blind studies in psychiatric research

Browne (2008)¹⁰⁵ makes a general criticism:

Because of their reliance on a reductionist scientific epistemology ... it is simply not possible for the majority of psychiatrists to address the essential nature of psychiatric illness. ... Psychiatric journals are full of statistical surveys and double-blind drug trials which purport to give a 'scientific' basis to modern psychiatric practice and to the biochemical causation of most psychiatric illness. ... I believe what lies behind these endeavours is a deep misunderstanding of the true nature of scientific research. Science is not synonymous with scientific method ... much psychiatric research has become debased, simply identified with scientific method and virtually devoid of originality.¹⁰⁶

Some more narrowly focused criticisms of the use of placebo-controlled, double blind studies in psychiatric research, which have been made in the academic literature, include:

Conclusions: ... Conventional antipsychotics should usually be used in the initial treatment of an episode of schizophrenia unless the patient has previously not responded to these drugs or has unacceptable extrapyramidal side effects.

¹⁰² See Chapter 4.

¹⁰³ A 'meta-analysis' is an analysis of studies which themselves tested a particular hypothesis, for example, that atypical anti-psychotic drugs are more effective at treating psychosis than first generation anti-psychotics.

¹⁰⁴ Parikh (2009) [References have been omitted].

¹⁰⁵ Ivor Browne was Professor of Psychiatry at University College, Dublin and Chief Psychiatrist to the Eastern Health Board.

¹⁰⁶ Browne (2008), pp.258-9.

- *The breaking of the blind*

Psychoactive drugs have side effects which are readily detectable to both the subject and the researcher thus defeating the double-blind. In an attempt to preserve the integrity of the double-blind, inert 'active' placebos (which seek to mimic the known side effects of the drug under test) have been used.¹⁰⁷

- *Publication Bias*

The value of evidence-based medicine is grounded entirely on the presumption that the evidence base is complete and unbiased. The selective publication of the results of clinical trials, or of the data from within these trials, negates any such presumption and can lead to unrealistic estimates of drug effectiveness.¹⁰⁸ Moreover, as pointed out by Chalmers:¹⁰⁹ "... *science as an error-detecting process simply ceases to exist in these circumstances.*"¹¹⁰

The selective publication of the results of clinical trials can take many forms: *e.g.* the selective reporting or non-reporting of negative trials or the multiple reporting of the same trial data in different academic journals (thus ensuring that the data will be overrepresented in subsequent meta-analyses).

Studies have sought to compare the data submitted to the regulatory authorities as a licensing requirement for a particular drug, with the data subsequently published in academic journals. Melander (2003), for example, examined data concerning 42 placebo controlled studies of antidepressants submitted to the Swedish regulatory authorities, with subsequently published studies. They found:

- *Multiple publication*: 21 studies contributed to at least two publications each and three studies contributed to five publications.

¹⁰⁷ Antonuccio (2002):

The double blind in these studies is likely to be unintentionally penetrated because of the pattern of side effects in the active and inactive drug conditions. ... Efforts to ensure the integrity of the blind tend to diminish drug efficacy. For example, a recent review of the Cochrane database of antidepressant studies using "active" placebos (making side-effect differences more difficult to detect) found very small or nonsignificant outcome differences, suggesting that trials using inert placebos may overestimate drug effects. [References omitted].

See also Moncrieff & Double (2003):

Active medication, such as antidepressants, may produce side effects that distinguish it from inert placebo tablets. People in the antidepressant group may then experience a so-called amplified placebo effect ...

... Some older studies compared antidepressants with 'active' placebos ... However, even in these studies participants could often distinguish between antidepressants and the active placebos, possibly because the antidepressants had more profound side effects.

¹⁰⁸ See, for example, Turner (2008), p.252.

¹⁰⁹ Sir Iain Chalmers is one of the founders of the Cochrane Collaboration and editor of the James Lind Library, institutions which are dedicated to the development of evidence-based medicine.

¹¹⁰ Chalmers (2006), p.340.

- Selective publication: studies showing significant effects of drugs were published as stand alone publications more often than studies with non-significant results.
- Selective reporting: many publications ignored the results of ‘*intention to treat*’ analyses and reported the more favourable ‘*per protocol*’¹¹¹ analyses only.

Melander (2003) concluded that:

The degree of multiple publication, selective publication, and selective reporting differed between products. Thus, any attempt to recommend a specific selective serotonin reuptake inhibitor from the publicly available data only is likely to be based on biased evidence.¹¹²

Turner (2008) examined the data submitted to the US drug licensing authority¹¹³ in relation to 12 antidepressant agents and searched the literature to identify matching publications and then compared the outcomes as submitted to the FDA, with the published outcomes; it concluded:

Among 74 FDA-registered studies, 31%, ... were not published. ... A total of 37 studies viewed by the FDA as having positive results were published; 1 study viewed as positive was not published. Studies viewed by the FDA as having negative or questionable results were, with 3 exceptions, either not published (22 studies) or published in a way that, in our opinion, conveyed a positive outcome (11 studies). According to the published literature, it appeared that 94% of the trials conducted were positive. By contrast, the FDA analysis showed that 51% were positive. Separate meta-analyses of the FDA and journal data sets showed that the increase in effect size ranged from 11 to 69% for individual drugs and was 32% overall.¹¹⁴

Such bias is not restricted to studies of antidepressants: Chan (2008)¹¹⁵ summarised the results of a wider study¹¹⁶ which examined new drug applications to the FDA:

Overall, a substantial amount of primary outcome data submitted to the FDA was found to be missing from the literature. One quarter of trials in their sample were unpublished – predominantly those with unfavorable results. Not only were data suppressed for the unpublished trials, but an additional quarter of primary outcomes were omitted from journal articles of published trials ... The vast majority of discrepancies favored the sponsor’s new drug, suggesting biased reporting.

- Lack of congruence between clinical and research environments

Cipriani (2009) *supra* in a review of 117 randomised controlled trials of second-generation antidepressants, noted that the quality of the trials was poor with only 12

¹¹¹ A ‘*per protocol*’ analysis incorporates only subjects who complete the entire clinical trial or other procedure analyzed, unlike an ‘*intention to treat*’ analysis which also includes the subjects who, for whatever reason, dropped out of the trial.

¹¹² Melander (2003), p.1171.

¹¹³ The Food and Drug Administration (FDA).

¹¹⁴ Turner (2008), p.252.

¹¹⁵ Chan (2008).

¹¹⁶ Rising (2008).

being rated as adequate;¹¹⁷ furthermore the duration of the trials was on average just over 8 weeks and was, in consequence, of limited use to clinicians:

Clinically, the assessment of efficacy after 6 weeks of treatment or after 16–24 weeks or more might lead to wide differences in treatment outcome. In many systematic reviews, the ability to provide valid estimates of treatment effect is limited because trials with different durations of follow-up have been combined.

Cipriani (2009) also noted the evidence of bias due to the influence of the pharmaceutical industry. Parikh (2009) (*supra*) in a review of Cipriani (2009), described the findings as having “*enormous implications*” and continued: “*Such research invites a key clinical question: is superiority at 8 weeks meaningful and sustained over a treatment that minimally lasts 6 months?*”¹¹⁸

The brevity of the test periods under which psychiatric drugs are assessed, the lack of systematic proactive research into the side effects of psychiatric medications,¹¹⁹ the use of polypharmacy¹²⁰ in clinical psychiatry suggest that the disparity between the conditions under which psychiatric medications are tested and under which they are used, is of such a scale as to render the results of initial drug testing of limited use in clinical situations even if the initial testing on such medications had been methodologically flawless.

Similar considerations have, in general medicine, led to a movement away from placebo-controlled, double blind studies towards ‘*Effectiveness Research*’¹²¹ which seeks to examine and record the ongoing ‘real world’ effects of treatment – death rates, side effects, progression of the disease – in individual patients with complex symptoms. David Healy¹²² suggests that the unwillingness of the pharmaceutical companies to conduct longer term research into either the longer term effectiveness or the side effects of pharmaceutical drugs may be:

¹¹⁷ Cipriani (2009): “*Most trials were rated as unclear according to our quality assessment and only 12 were rated as adequate.*”

¹¹⁸ Parikh (2009).

¹¹⁹ See Appendix I.

¹²⁰ The concurrent use of multiple medications.

The Irish Inspector of Mental Hospitals has stated:

The number of patients, particularly long-stay patients, who are on numerous drugs simultaneously, often at high dosages, was striking. In some instances, the prescriptions had not been reviewed for some considerable time. [Walsh (1998), pp.3-4.]

See also Kingdon (2004) who had conducted a survey of psychiatrists: “*Many think that antipsychotic medication is prescribed above British National Formulary (BNF) limits too often and that polypharmacy is too common.*” (p.402)

¹²¹ Kolata, G. (2008). ‘The Evidence Gap: New Arena for Testing of Drugs: Real World.’ *The New York Times*. 24 November.

¹²² David Healy, a psychiatrist, is Professor in Psychological Medicine at Cardiff University College of Medicine.

... because their lawyers may have given them advice that echoes that given to tobacco companies: that any investigation of these issues may increase claims of product liability.¹²³

The distorting effects wrought by pharmaceutical company influence on academic psychiatry and published psychiatric research is discussed in *Appendix J* where it is concluded *inter alia*, that:

The influence of the pharmaceutical industry on the nature, conduct and reporting of psychiatric research is pervasive, often hidden, and is of such a magnitude as to cast doubt on the impartiality, objectivity and evidence base of much published research.

Most of the indicators of the extent, and effects, of this influence were uncovered as a by-product of litigation or US congressional investigation; as such, it was neither systematic nor could it necessarily be said to be indicative of psychiatric pharmaceutical treatment considered generally nor, *a fortiori*, of general coercive pharmaceutical psychiatric treatments.

In contrast, the focus of *Appendix K* and *Appendix L* is such as to enable the drawing of conclusions concerning the evidence base for coercive pharmaceutical psychiatric treatments considered generally.

The method adopted is to consider two of the commonest psychiatric treatments – antidepressants [*Appendix K*] and antipsychotics [*Appendix L*] – and to discuss some of the research findings which have been published over the last decade, which have led to the undermining of what were, at the beginning of the decade, considered to be near-indubitable ‘certainties’ concerning the safety and efficacy of these treatments.

Assessments of the robustness of the evidence base for either antidepressants or antipsychotics permit conclusions to be drawn regarding the robustness of the evidence base for coercive pharmaceutical psychiatric treatments considered generally:

- in that antidepressants are the most widely used psychiatric medication,¹²⁴ the standard of research into their efficacy and safety serves as a touchstone for the standard to be expected to prevail in relation to the evidence base for other pharmaceutical psychiatric treatments and, in particular, coercive pharmaceutical psychiatric treatments. An application of the *Precautionary Principle* would – in the absence of compelling evidence to the contrary – validate any such generalisation.

¹²³ Healy (2002), p.374; Healy was referring specifically to anti-depressants but his analysis is applicable to all psychoactive drugs.

¹²⁴ See, for example, Pincus (1998) and Paulose-Ram (2007).

- because antipsychotics are the standard treatment for schizophrenia and because (as has been argued)¹²⁵ schizophrenia serves as a surrogate for those psychiatric conditions which commonly precipitate a coercive intervention, the robustness of the evidence base for antipsychotics can serve as an indicator for the robustness of the evidence base for general coercive pharmaceutical psychiatric treatments.

B.2.2: Conclusions concerning published research on antidepressants and antipsychotics

B.2.2.1: A conclusion concerning research on antidepressants [Appendix K]

Subsequent analyses of earlier research into the efficacy and safety of antidepressants which lead to the uncovering of serious methodological flaws, in addition to disclosures concerning the influence of pharmaceutical industry on the publication of trial data, undermines – in the absence of compelling evidence to the contrary – the claims of published research on antidepressants to being evidence-based and to being either efficacious or safe.

B.2.2.2: Conclusions concerning research on antipsychotics [Appendix L]

1. The inference to be drawn from the existence of grossly inconsistent results in relation to trials of first and second generation antipsychotics, is that some supposedly evidence-based studies supporting the psychiatric use of antipsychotics, are deeply flawed.

2. There is a manifest reluctance amongst clinical psychiatrists to changing their beliefs in relation to the appropriate prescribing of antipsychotics, in the face of authoritative disconfirming evidence relating to the safety and efficacy of atypical antipsychotics.

3. There are substantial grounds for holding not only that the extent and the severity of harms associated with the use of antipsychotics have been grossly underestimated both by researchers and by clinical psychiatrists, but that even when the magnitude of such harms has been conclusively established, it has not informed the beliefs of psychiatrists as reflected in their prescribing habits.

Section C: Current psychiatric practice and the Section A principles: treatment based solely on the interests of the subject?

C.1: Some preliminary matters

The use of both physical and chemical restraint in psychiatry is examined by Currier & Allen (2000) who advert to the problem of distinguishing between a chemical given as a ‘treatment’ and that same chemical given as a ‘restraint’ and suggest that the distinction

¹²⁵ See Chapter 4.

hinges on whether an agent is given as a part of the treatment of the patient's condition or simply to control the patient's behavior.

The solution advocated by the US Health Care Financing Administration (HCFA) was to focus on the process of prescribing:

If a medication is prescribed as part of an assessment and rational plan of care, whether on a scheduled or an as-needed basis, it is a treatment. If prescribed simply as a reaction to the patient's behavior, it is a restraint.¹²⁶

Under HCFA guidelines the use of restraint for "*managing behavioral emergencies*" is allowed:

... *only when all less restrictive measures have failed and unanticipated severely aggressive or destructive behavior places the patient or others in imminent danger of self-harm.*"¹²⁷

Currier & Allen (2000) note that these guidelines would preclude the use of restraint "*... to maintain an orderly therapeutic milieu, which has been permissible in some jurisdictions ...*"¹²⁸

Unlike a physical restraint which clearly bespeaks its purpose, a chemical restraint does not and because some chemical psychiatric treatments – *e.g.* antipsychotics – have a calming or indeed, stultifying effect on the subject, they may be used either as a treatment or as a restraint. The problem for an outside observer is, in any given situation, to distinguish between these alternatives; to focus on the psychiatrist's intent as suggested above, does not – as the following case shows – adequately address the difficulty.

C.1.1: The Bigley Case¹²⁹

This was an Alaskan case involving a Mr. William Bigley who had been diagnosed as psychotic. He had been coercively medicated with various antipsychotics (including Zyprexa) over many years but always stopped his medication on release from hospital because of the unpleasant side effects of the drugs. The case arose from an application by a psychiatric hospital that Bigley be forcibly medicated with Zyprexa though "*The records also show that neither Zyprexa nor any other drug has given Mr. Bigley any lasting relief*". Bigley refused to consent to treatment with antipsychotics. Under Alaskan law, Bigley could only be forcibly medicated if it were shown that he was

¹²⁶ Currier & Allen (2000), p.718.

¹²⁷ *Ibid.*

¹²⁸ *Ibid.*

¹²⁹ The details of the Bigley case are taken from Berenson, A. (2008b). 'One Drug, Two Faces.' *The New York Times*. 25 March.

“*violent, suicidal or a grave danger to himself*”; he had never been shown to be violent or suicidal.

In giving evidence, the hospital psychiatrist said that Bigley:

... had irritated the staff and other patients. “*He’s yelling, swearing on the unit, he hit the door,*” ... Antipsychotic medication would calm Mr. Bigley and make him more cooperative, the doctor said.

... was in grave danger because he might irritate other people, including police officers, to the point where he might end up being hurt. “*He’s very inappropriate,*” Dr. Raasoch said. “*He gets up in people’s faces. I think the majority of people would just punch him.*”

... “*There’s no point to have a psychotic individual in the hospital and not be able to treat him,*”¹³⁰ he said. “*I think he’s suffering severe distress.*”

Surprisingly¹³¹ the judge – adopting the prosecutor’s argument that “*The hospital has not shown that treatment will improve him.*” – refused the psychiatrist’s request.

Had the psychiatrist’s request been acceded to, would the coercive administration of antipsychotics be a treatment or a restraint? The intent of the psychiatrist was to ‘treat’ the subject and not to restrain him, accordingly it would have passed the HCFA test (*supra*) but it would not, as understood by the court, have been a treatment. Doubtless the psychiatrist might have responded that by lessening the possibility of Bigley being assaulted by others in response to his conduct, the forcible medication with antipsychotics would have benefited him and was, thus, a ‘treatment’.

The conclusion to be drawn from the case is that, in relation to the coercive administration of drugs, ‘treatment’ is to be distinguished from ‘restraint’ by analysing the primary intent; if the primary intent is to restrain then any secondary intent is not relevant.

It should be noted that had a court application not been required – as is the situation in Ireland – the coercive administration of antipsychotics as a mechanism of restraint rather than treatment, would have taken place in the absence of public scrutiny.

In situations such as the Bigley case, the assessment of whether the administration of a psychiatric medication is a ‘restraint’ or a ‘treatment’ occurs concurrently with its administration; however the retrospective assessment of whether the interests of those

¹³⁰ A perspective which echoes that of ter Meulen’s (2005) (*supra*): “... *in clinical practice there is a duty to act.*” The absence of treatment makes the role of the psychiatrist (*qua* psychiatrist) questionable in that it suggests that he is acting as little more than a gaoler. See also Ballard (2005) *infra* who speaks of medical interventions arising from a “*fear of therapeutic impotence.*”

¹³¹ Berenson (2008b) (*supra*): “... *judges prefer not to second-guess doctors and typically rubber-stamp the requests of hospitals to confine and medicate patients.*”

other than the subject were determinative of a treatment decision¹³² is more problematic in that, whilst a treatment decision may (at the time it was made) have reflected solely the interests of those other than the subject, the decision – when viewed retrospectively – may not be unambiguously referable to such interests unless the circumstances are such that the treatment decision (at the time it was made and with the knowledge then available) was clearly contrary to the interests of the subject. As previously mentioned the lack of adequate record keeping in Irish psychiatric hospitals¹³³ considerably complicates any attempt at retrospective assessment.

To enable the analysis to be developed, examples will be given below where the use of antipsychotics appears to have been clearly contrary to the interests of the subject; such a use has been described by the phrase ‘*chemical cosh*’.¹³⁴ The examples to be discussed are:

- the prescribing of antipsychotics to elderly patients [Subsection C.2];
- the prescribing of antipsychotics to intellectually challenged adolescents [Subsection C.3].

These examples have been chosen firstly because more directly relevant examples¹³⁵ are not readily available and secondly, because in these examples the detriment to the patients is unambiguously evident.

The lack of more directly relevant examples is not a serious hindrance because the Precautionary Principle can be invoked to enable general conclusions to be drawn relating to the coercive use of antipsychotics for reasons other than the interests of the subject (or their possible dangerousness¹³⁶) [Subsection C.4].

C.2: Non therapeutic use of antipsychotics in the elderly

The extent of antipsychotics usage in the management of the elderly is discussed in C.2.1; the risks associated with such usage, in C.2.2. The prescribing of antipsychotics for the elderly in Ireland is discussed in C.2.3 and its possible inappropriateness, in C.2.4.

¹³² The use of the term ‘treatment decision’ to cover what may not, on analysis, be a ‘treatment’ but a ‘restraint’ is problematic but appears to be sanctioned by usage.

¹³³ See Walsh (1998) *supra*.

¹³⁴ See Ballard (2005) *supra*.

¹³⁵ *I.e.* cases where, in the absence of dangerousness, antipsychotics are routinely administered for what is essentially, the interests of others.

¹³⁶ The protection of the (legitimate) interests of others (*e.g.* ‘dangerousness’) is not included in the analysis undertaken in the present chapter; it is the focus of Chapter 6.

C.2.1: The extent of antipsychotics usage

Schweizer (2003), having noted findings that US nursing homes used psychoactive drugs as ‘chemical restraints’ in order to reduce the need for staff, examined the usage of such drugs in nursing homes in Northern Ireland. Previous researchers had reported prescribing rates for psychoactive medication of around 60% for nursing home residents; Schweizer (2003) reported a rate of 72.8% of which “... *only 21% had a suitable diagnosis ... recorded in their medical notes.*”; 28% had been prescribed antipsychotics of which only 21% had an appropriate diagnosis. The study also noted a correlation between low staffing levels and high psychoactive drug usage, suggesting that the drugs were being used as “*substitutes for staff*”.

A Canadian study found even more disturbing results:

... an average of 31.3% of all residents were receiving antipsychotics. ... Only 8.1% of prescriptions had accompanying documentation on the behavioral indication for the use of antipsychotics.¹³⁷

A Norwegian study¹³⁸ documented the practice in nursing homes, of concealing antipsychotics in patients' foodstuff; it found that in 60% of cases, the practice was undocumented.

Briesacher (2005) identified a sample of 2.5 million Medicare beneficiaries in nursing homes during 2000-2001 and assessed both the prevalence and appropriateness of antipsychotic use. They found that:

... 27.6%, ... received at least 1 prescription for antipsychotics during the study period ... Less than half (41.8%) of treated residents received antipsychotic therapy in accordance with NH prescribing guidelines.¹³⁹

It can be concluded that there is robust evidence indicating high levels of inappropriate use of antipsychotics amongst those elderly who are in nursing home care.

C.2.2: Conventional and atypical antipsychotics: the risks

In 2005, the FDA issued a warning that the use of atypical antipsychotics in the treatment of elderly patients “*nearly doubled the risk of death, as compared with the risk with placebo, ...*”.¹⁴⁰

This warning did not extend to conventional antipsychotics and Wang (2005) sought to determine if conventional antipsychotics were safer than atypical antipsychotics in the

¹³⁷ Hagen (2005).

¹³⁸ Kirkevold & Engedal (2004); it also found that 11% of nursing home patients routinely received drugs mixed in with their food.

¹³⁹ Briesacher (2005), p.1280.

¹⁴⁰ Wang (2005), p.2336.

treatment of the elderly. Having studied 22,890 elderly persons commencing antipsychotic medication, he concluded that those taking conventional antipsychotics:

... had a 37 percent higher, dose-dependent risk of death in the short term than those for whom atypical agents were prescribed. To place this magnitude of risk in perspective, only cancer, congestive heart failure, and HIV infection conferred greater adjusted risks in our analyses.¹⁴¹

Mortimer (2005) whose study on the prescribing of antipsychotics in primary care was discussed earlier, noted that:

There is no shortage of material advising against the practices which we, and others in the field, have encountered. Patients without schizophrenia and the elderly may be particularly liable to serious side effects of antipsychotic drugs.¹⁴²

Schneeweiss (2007) studied 37,241 elderly residents who began taking antipsychotic therapy during the study period, and concluded that:

... patients prescribed a conventional agent had a 32% greater, dose-dependent risk of death within 180 days than did those given an atypical agent. To place this magnitude of risk in perspective, all measured health conditions except congestive heart failure and HIV infection conferred smaller adjusted mortality rate ratios in our analyses.¹⁴³

The risks associated with antipsychotics use in the treatment of the elderly, were also significantly higher than with other psychoactive medications.¹⁴⁴

Douglas & Smeeth's (2008) (*supra*) found that the risk of stroke in elderly people treated with antipsychotics,¹⁴⁵ increased by factors of between two- and five-fold and concluded that: "... *the use of antipsychotic drugs in these patients should be avoided whenever possible.*"

An editorial accompanying the publication of Ray (2009) (*supra*) which had analysed the risk of sudden cardiac death associated with the use of antipsychotics questioned whether their use should be restricted as: "*In the absence of clearly established benefits for many of these patients, the risk of a fatal side effect is not likely to be acceptable.*"¹⁴⁶

Ballard (2009) sought to determine whether the continued treatment of patients with Alzheimer's disease (AD) led to an increase in mortality and to that end, half their study population continued treatment with antipsychotics and the remainder received a placebo. The study concluded that the use of antipsychotics lead to a persistent and increased risk of mortality, with the risk increasing in proportion to the duration of

¹⁴¹ *Ibid.*

¹⁴² Mortimer (2005).

¹⁴³ Schneeweiss (2007), pp. 630-631.

¹⁴⁴ Kales (2007).

¹⁴⁵ See Table L-1 in Appendix L.

¹⁴⁶ Schneeweiss & Avorn (2009) (*supra*) [References omitted].

exposure and urged clinicians to: “... *try to replace antipsychotics with safer management approaches.*”¹⁴⁷ They noted that:

Several studies have shown that psychological management can replace antipsychotic therapy without any appreciable worsening of neuropsychiatric symptoms ...¹⁴⁸

An accompanying editorial reiterated the need for psychosocial – rather than pharmaceutical – methods of managing challenging behaviour, noting that any benefit of antipsychotics was at best short term,¹⁴⁹ and that in order to “*protect the health and dignity of people with dementia*” the use of antipsychotics should be curtailed.

The methodology adopted by Ballard (2009) is worthy of note in that by its use of a drug-free arm, it challenged the supposedly ethics based argument¹⁵⁰ against using such a drug-free arm in tests on the safety and efficacy of antipsychotics in the treatment of schizophrenia.

The discussion in this subsection may be summarised in the conclusion that:

The use of either conventional or atypical antipsychotics in the treatment of the elderly, doubles the risk of death; this exceeds the risk of death due to any other medical conditions other than that of congestive heart failure or HIV. The risk is considerably exacerbated in the presence of dementia.

C.2.3: The prescribing of antipsychotics for the elderly in Ireland

Meaney & Cooney (2003) examined the prescribing of antipsychotics by psychiatrists to elderly subjects in Ireland and concluded that though Irish psychiatric practice was, in this regard, similar to that of other countries: “... *on occasion, extraordinarily high doses of antipsychotics are being prescribed.*”¹⁵¹

Campbell (2006) found that 26% of patients in private nursing home care had been prescribed antipsychotics. The medical correspondent of *The Irish Times* summarised the results of another study which found similar levels [23.2%] of antipsychotic use in Irish nursing homes and that 51% were receiving the drugs inappropriately:

¹⁴⁷ Ballard (2009), p.154:

... the cumulative survival was 46% versus 71%, respectively, between the continued treatment and placebo groups at 24 months, 30% versus 59% at 36 months, and 26% versus 53% at 42 months.

¹⁴⁸ *Ibid.*, p.157.

¹⁴⁹ Lancet Neurology (2009).

¹⁵⁰ See Sikich (2008) (*supra*) who mentioned that the use of a drug-free arm in testing antipsychotics for the treatment of schizophrenia, was objected to as contravening the *Helsinki Declaration*.

¹⁵¹ Meaney & Cooney (2003), p.64.

Among the reasons given for using anti-psychotic drugs inappropriately were restlessness, patients being prone to wandering, and intermittent aggression from patients. ... patients who were calling out, shouting or spitting.¹⁵²

In 2006 an Irish psychiatrist, Dr. Corry, in oral testimony to the *Oireachtas Sub-Committee on the Adverse Side Effects of Pharmaceuticals*, spoke of the fatalities in the elderly due to the use of antipsychotics: “Almost 18% died. It is staggering stuff. If Olanzapine was a car, it would be taken off the market. This is a disgrace.”¹⁵³

In 2011, a report funded by the Centre for Ageing Research and Development in Ireland, found that:

... 73 per cent of those surveyed in the Republic were receiving at least one potentially inappropriate medicine ... Nearly one-fifth of those reviewed were receiving three or more inappropriate medicines.¹⁵⁴

A clinical psychologist (Dr. Brian McClean) has also studied the use of inappropriate medications in institutional care in Ireland:

“Many people are placed on anti-psychotic medications even though they do not have psychotic illnesses.” They are used, therefore, not for a treatment effect, but for sedative side-effects, he said. “Even worse than the over-use of anti-psychotic medication is the widespread use of anti-anxiety medication. They are only licensed for short-term use, yet many people in large residential settings are on high doses of these medications for many years.”¹⁵⁵

C.2.4: The inappropriate prescribing of antipsychotics to the elderly despite the known risks.

Ballard (2005) notes that though 90% of dementia sufferers develop behavioural or psychiatric symptoms at some point in their illness:

... that does not legitimize widespread use of dangerous treatments. ... we prescribe because of fear of therapeutic impotence and not because of the best interests of the patient. ... Given the often catastrophic effects of treatment, in the context of dementia, it is difficult to see how neuroleptic treatment can be in the best interests of anyone other than the harassed doctor making the prescription.

In a subsequent discussion Ballard was even more forthright:

As clinicians we talk about “the best interests of our patients”. How can a treatment which doubles the rate of cognitive decline, triples the rate of stroke, doubles mortality, substantially increases falls and fractures and reduces quality of life be beneficial, especially, as in real life, once neuroleptics are started they are

¹⁵² Houston, M. (2006). ‘Medication misused to placate 51% of patients with dementia - study’. *The Irish Times*. 6 June.

¹⁵³ Dr. Corry continued:

I have worked as a psychiatrist for 30 years. I have degrees in obstetrics and paediatrics. I have worked in Africa as a surgeon. I know what good and bad sciences are. The science that has taken place in psychiatry is Humpty Dumpty science. There is no scholarship in psychiatry. What has gone on in the field is absolutely appalling.

Oireachtas Sub-Committee on the Adverse Side Effects of Pharmaceuticals (2006), 17 Oct.

¹⁵⁴ Carr, W. (2011). ‘Concern over medicine use for elderly.’ *The Irish Times*. 7 April.

¹⁵⁵ Hough, J. (2011). ‘Institutions ‘use drugs to subdue residents’’. *The Irish Times*. 18 April.

rarely discontinued with cumulative adverse effects? ... Doctors, especially specialists feel they need to do something, and prescribing a familiar drug is the easiest option. ...¹⁵⁶

In a 2008 BBC interview, Ballard – who is Professor of Old Age Psychiatry at the University of Newcastle – noted that up to 60% of Alzheimer's patients in nursing homes are given antipsychotics and that just six months of treatment was enough for patients to show a marked deterioration in their verbal fluency.¹⁵⁷

A contemporaneous report in *The New York Times* noted that “*despite a drumbeat of bad publicity*”, a third of all nursing home patients have been given antipsychotic drugs.¹⁵⁸ The report also discussed the use of alternative, drug-free, therapies:

Some nursing homes are trying a different approach, so-called environmental intervention. The strategies include ... providing intellectual and physical stimulation, exercise, calming music, Some doctors point out that simply paying attention to a nursing home patient can ease dementia symptoms. They note that in randomized trials of antipsychotic drugs for dementia, 30 to 60 percent of patients in the placebo groups improved. “*That's mind boggling ... They receive both T.L.C. and good general medical and humane care, which they did not receive until now. That's a sad commentary on the way we treat dementia patients.*”¹⁵⁹

In 2008, in response to widespread concerns of the overprescribing of antipsychotics the BBC ‘*File on 4*’ programme commissioned a survey of GPs to determine their levels of, and reasons for, prescribing antipsychotics to elderly patients.¹⁶⁰

Extent of prescribing¹⁶¹

Of the doctors surveyed, only 4% stated that they would never prescribe antipsychotics to elderly patients; the average proportion of elderly patients for whom antipsychotics would be prescribed was 15.7% with some doctors prescribing for 90% of such patients; 45% of doctors had prescribed on a PRN basis (*i.e.* to be administered as needed).

¹⁵⁶ [online], available: http://www.biomedexperts.com/Abstract.bme/15945588/Drugs_used_to_relieve_behavioral_symptoms_in_people_with_dementia_or_an_unacceptable_chemical_cosh_Argument [accessed: 2 April 2009].

In a further interview, Ballard stated: “*If this was a massive increase in mortality in children there would be an outcry.*” [See Curtis, P. (2007). ‘Alzheimer’s sufferers dying in drug ‘scandal’.’ *The Guardian*. 30 March.]

¹⁵⁷ BBC (2008). ‘Medication ‘worsens Alzheimer’s.’ *BBC*. 1 April. [online], available: <http://news.bbc.co.uk/2/hi/health/7319393.stm> [accessed: 2 April 2009].

¹⁵⁸ Tarkan, L. (2008). ‘Doctors Say Medication Is Overused In Dementia.’ *The New York Times*. 24 June. As the FDA had not approved antipsychotics as a treatment for dementia, such a use is off-label; though an off-label use is not necessarily a misuse, the report stated that “*many doctors say misuse of the drugs is widespread.*”

¹⁵⁹ Reported comment of Dr. Jeste, Professor of Psychiatry and Neuroscience at the University of California, San Diego.

¹⁶⁰ The survey questionnaire [Medix (2008)] and the programme transcript [BBC (2008)] are available.

¹⁶¹ Data, not more particularly ascribed, is taken from BBC (2008).

In 2004, the UK Committee on Safety of Medicines had issued a warning regarding the use of Risperidone and Olanzapine in the treatment of the elderly yet these were the first and third most common antipsychotics to be prescribed.

During the period 2003-2008, 700 deaths in the elderly were attributed to the use of antipsychotics.¹⁶²

Reasons for prescribing

The responses are collated in the following table.¹⁶³

None	4%
Passivity	3%
Aggression	84%
Wandering	24%
Inappropriate behaviour	51%
Disinhibition	44%
Noisy	14%
Other, please specify	15%

Table 5-1: Reasons for prescribing antipsychotics to the elderly

Commenting on the results, the Chairman of the UK All-Party Parliamentary Group on Dementia noted:

Antipsychotic drug medication is being prescribed to keep people quiet. It's not being prescribed for a therapeutic purpose, it's not being prescribed even for a medical purpose, it's being prescribed because of the absence of other coping mechanisms.¹⁶⁴

Expert comments on survey results

Ballard believed that about 70% of those elderly being prescribed antipsychotics don't need them:

... despite that many of the kind of hazards and risks of this have been clear for five years or longer, there has been very very little change in the rates of prescription.¹⁶⁵

Sommerville¹⁶⁶ noted that the US had instituted legal reforms¹⁶⁷ which resulted in about a 66% reduction in the number of elderly being prescribed antipsychotics: "I've read in many papers their description of people waking up, having a better quality of life."¹⁶⁸

¹⁶² Compiled by the UK Yellow Card scheme for Adverse Drug Reactions.

¹⁶³ Medix (2008), p.6.

¹⁶⁴ BBC (2008), p.11.

¹⁶⁵ BBC (2008), p.5.

¹⁶⁶ Hazel Sommerville, Head Pharmacist to the UK Commission for Social Care Inspection.

¹⁶⁷ BBC (2008), p.12:

The Americans approach this from a two-fold angle, both are through federal law. Firstly, they've described a range of diagnosis that a doctor may prescribe an antipsychotic drug for, and they also detail the dose and length of treatment *etc.* It's really very precise clinical standard of management. But secondly, they have stated in law that everyone has the right to be free from

Kendall¹⁶⁹ stated:

It's horrifying to think that there must be some GPs out there – and it clearly isn't a small number – giving these drugs routinely. ... A doctor prescribing for 90% of their patients an antipsychotic when there is enough guidance out there to say don't do it, it's unacceptable, and I do think that should be a disciplinary matter.¹⁷⁰

Interviewed in 2009, Kendall stated:

When doctors routinely ignore the evidence in this flagrant way, as recent surveys seem to suggest, for a group of people who are disenfranchised and very dependent, it should be considered a very serious matter indeed.¹⁷¹

The above discussion enables the conclusion to be drawn that :

The existence of widespread prescribing of antipsychotics to the elderly in circumstances where this is clearly against their interests, indicates that such medications are being administered solely in the interests of others.

C.3: Non-therapeutic use of antipsychotics in the intellectually disabled

Tyrer (2008) introducing his study, states:

Aggressive challenging behaviour is frequently reported in adults with intellectual disability and it is often treated with antipsychotic drugs. However, no adequate evidence base for this practice exists.¹⁷²

His study tested a conventional antipsychotic, an atypical antipsychotic and a placebo in a group of intellectually challenged, non-psychotic, subjects who presented with “aggressive challenging behaviour.”

Tyrer (2008) noted that antipsychotic use:

... has become commonplace, with between 22% and 45% of people with intellectual disability in hospital and about 20% of those in the community being prescribed antipsychotic drugs.¹⁷³

The study concluded that:

Although we noted a reduction in aggression with all treatments after 4 weeks, the greatest decrease was with placebo.¹⁷⁴

chemical restraint imposed for the convenience of others. And to support that stance, they require the long term nursing facilities to arrange for a pharmacist to conduct medication review of every patient once a month.

¹⁶⁸ BBC (2008), p.12.

¹⁶⁹ Kendall led the NICE review on the use of antipsychotics in the treatment of the elderly and is deputy director of the Royal College of Psychiatrists' Research Unit.

¹⁷⁰ BBC (2008), p.7.

¹⁷¹ BBC (2009). 'Dementia drug death risk warning.' *BBC*. 9 January. [online], available: <http://news.bbc.co.uk/2/hi/health/7817583.stm> [accessed: 3 April 2009].

¹⁷² Tyrer (2008), p.57.

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid.*, p.61 [Emphasis added].

Antipsychotic drugs should no longer be regarded as an acceptable routine treatment for aggressive challenging behaviour in people with intellectual disability.¹⁷⁵

Tyrer (2008) noted that his findings accorded with a 1998 study which expressed concern at the “*overuse of psychotropic medication to ‘treat’ challenging behaviour in people with intellectual disability*” without any evidence of contemporaneous mental illness,¹⁷⁶ a concern which did not appear to be reflected in any decrease in the use of antipsychotics in such circumstances. Tyrer (2008) also spoke about the dangers of using ‘*problem behaviours*’ as a diagnosis, calling it a ‘*pseudodiagnosis*’;¹⁷⁷ he argued that though antipsychotics might have a limited role as an emergency measure, research into the use of “*psychological interventions*” should be actively pursued.¹⁷⁸

A *Lancet* editorial¹⁷⁹ whilst praising the methodology used by Tyrer (2008), noted that its conclusion “... *is a departure from conventional wisdom. Additionally, there are several factors that might hinder a change in practice.*”¹⁸⁰ The authors listed a number of such factors¹⁸¹ which they believed to be of such potency that “... *attempts to minimise drug use, while a worthy goal, may be difficult to achieve on a large scale.*”¹⁸²

Subsequent correspondence to the *Lancet*, whilst damning Tyrer (2008) with faint praise, were dismissive of its likely effect on clinical practice:

Although a welcome catalyst for debate, their finding that placebo was equally effective¹⁸³ has unfortunately already received simplistic media attention and will inevitably cause anxiety for many carers and professionals.¹⁸⁴

In addition, the study fails to appreciate the frequently overwhelming pressure from others to prescribe antipsychotics ...¹⁸⁵

In subsequent interviews, Tyrer summarised his view that the appropriate response to challenging behaviour in the intellectually challenged, was not the administration of antipsychotics, but an attempt to deepen personal contact:

¹⁷⁵ *Ibid.*, p.57.

¹⁷⁶ *Ibid.*, p.62.

¹⁷⁷ *Ibid.*

¹⁷⁸ *Ibid.*

¹⁷⁹ Matson & Wilkins (2008).

¹⁸⁰ *Ibid.*, p.9.

¹⁸¹ For example:

- the conflict between biological and behavioural theories in psychiatry;
- the use of antipsychotics as a prophylactic against the emergence of challenging behaviour;
- inadequate staffing levels;
- the unwillingness of nursing staff to accept responsibility for psychosocial intervention.

[*Ibid.*, pp.9-10.]

¹⁸² Matson & Wilkins (2008), p.10.

¹⁸³ The study had actually shown placebos to be *superior* to antipsychotics.

¹⁸⁴ Troller (2008).

¹⁸⁵ Turk (2008) [Emphasis added].

Being in the study, with all the extra attention it brought, was itself what apparently made the difference. ... These people tend to get so little company normally, ... They're neglected, ...¹⁸⁶

An example of the gravity of harm caused by such use of antipsychotics

The seriousness of the harm was highlighted in a BBC investigation¹⁸⁷ undertaken in 2009 which was precipitated by reports of birth defects in children of mothers who had been given high doses of sedatives and antipsychotics whilst in care homes in England in the 1970s and 1980s.

The birth defects (such as brain tumours, hydrocephalus and learning difficulties) occurred in children of ten of the girls in one care home who had been given the drugs, but were absent in the children of two of those girls who had not. The medications had not been used in the treatment of any diagnosed mental illness, but as a mechanism of restraint and had been given under the instruction of a Home Office psychiatrist who was reported to have stated at the time that the drugs were safe and did not have side effects.

The individual treatment records were given to a leading clinical pharmacologist¹⁸⁸ who said that the use of such medication was "... *unacceptable [and] would act as what people used to call a chemical cosh.*" He also stated that such a cocktail of drugs can cause genetic abnormalities:

Changes in genes and chromosomes induced by drugs may lead to birth defects or abnormalities later in life, ... But the fact that there were 10 of them affected in this is quite suggestive.

In Ireland, allegations of serious physical abuse of patients by staff in two Mental Hospitals in County Tipperary were initially investigated by the local hospital authorities; this investigation was dilatory in the extreme and a further inquiry under the aegis of the Mental Health Commission, was commissioned which reported in 2009.¹⁸⁹ In the course of its investigations, the inquiry commented on the high use of psychoactive medications by intellectually disabled residents and found that the

¹⁸⁶ Carey, B. (2008). 'Drugs Offer No Benefit in Curbing Aggression, Study Finds'. *The New York Times*. 4 January.

¹⁸⁷ The information and quotations in this and the following paragraphs are drawn from:

(i) Stickler, A. (2009). 'Living with the legacy of care.' *BBC Radio 4, Today programme*. 7 April. [online], available:

http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/today/hi/today/newsid_7982000/7982021.stm?ad=1 [accessed: 7 April 2009].

(ii) BBC (2009). 'Sedation link' to birth defects.' *BBC News*. 9 April. [online], available:

http://news.bbc.co.uk/2/hi/uk_news/7985912.stm [accessed: 7 April 2009].

¹⁸⁸ Jeffrey Aronson is Professor of Clinical Pharmacology at Oxford University and President of the British Pharmacological Society.

¹⁸⁹ MHC (2009); the report is discussed in Appendix J.

medications were being used inappropriately: "... to control their behaviour in the absence of needs-based therapeutic and recreation activities."¹⁹⁰ The report found that, in relation to some wards, more than half of the patients were sedated on a long term basis.¹⁹¹ The report gently chided the hospital authorities for this situation but declined to assign responsibility or to criticise any individual member of staff despite the absence of adequate care plans and the dearth of psychiatric supervision of patient care.¹⁹² It is noteworthy that the inquiry was prompted by concerns over the number of fractures suffered by residents at the hospitals and not by evidence of inappropriate use of medication uncovered by the Inspectorate. An examination, for example, of the *Report of the Inspector of Mental Health Services 2008* for the two hospitals in question,¹⁹³ whilst critical of individual aspects and of the absence of adequate individual care plans¹⁹⁴ made but no mention of the use of medication as a mechanism of restraint.¹⁹⁵ The lack of urgency into the investigation of possible patient abuse allied to the lack of accountability for inappropriate use of medication re-emphasises the need for adequate judicial supervision of the psychiatric services.¹⁹⁶

The above discussion permits the conclusion to be drawn that:

- (i) *the practice of administering antipsychotics and other psychoactive medications to the intellectually disabled as a 'chemical cosh', is widespread.*
- (ii) *Psychiatrists manifest an unwillingness to change their clinical behaviour in the face of clear evidence that non-therapeutic sedation is an ineffective and damaging method of managing challenging behaviour in the intellectually disabled.*

¹⁹⁰ O'Brien, C. (2009). 'Patients sedated improperly, report says.' *The Irish Times*. 4 April.

¹⁹¹ MHC (2009):

9.9a. The majority of residents received benzodiazepines on a long-term basis, which is usually considered to be undesirable. This seemed, in part, to be a result of a lack of activities and alternative treatment options. ...

21.5.3. More than half the residents of two wards, many with intellectual disability, were prescribed long term treatment with benzodiazepines. The pattern of prescribing was not in line with good practice guidance issued by the Department of Health and Children in 2002.

¹⁹² E.g. MHC (2009):

6.4.5. Reviews: There was no system for routine psychiatric review of the residents; this was done on a needs basis. Some physical examinations were recorded but these were not carried out six monthly, as required by the Regulations.

¹⁹³ MHC (2008a) and MHC (2008b).

¹⁹⁴ Though the report on St. Luke's Hospital, Clonmel stated [MHC (2008a), p.2]:

On the day of the inspection, the Inspectorate had serious concerns regarding the care and treatment of residents in St. Bridget's Ward and St. John's Ward. These concerns were immediately reported to the Registered Proprietor and the Mental Health Commission.

The authority of the inspectors recommendations appears to be limited in that the 2007 Report had recommended that "*Admissions to the hospital should cease. Outcome: There was no progress on this recommendation.*"

¹⁹⁵ Though it did discuss physical or mechanical restraint.

¹⁹⁶ In Ireland, this can most easily be accomplished by the repeal of S.73 of the *Mental Health Act* (2001).

C.4: Conclusions concerning the use of antipsychotics as a 'chemical cosh'

As shown in Subsections C.2 and C.3 (*supra*), the practice of using antipsychotics and other psychoactive medications, for the purposes of non-therapeutic sedation is widespread in relation to the elderly and the intellectually disabled. Intermittent aggression, shouting, spitting, unsociability and uncooperativeness have been reported as being the trigger for the unjustified administration of neuroleptic medication; it has also been used as a prophylactic against the possible emergence of challenging behaviour. Staff shortages and time pressures have also been offered as reasons for such non-therapeutic medication.

Is there any reason to expect that such behaviour, or similar staff shortages, might be less common in a psychiatric hospital setting or that they might warrant a less interventionist response? A direct scrutiny of the use of antipsychotics for non-therapeutic reasons, in general psychiatric hospitals would clearly have been preferable to an excursus into their use in homes for the elderly and the intellectually disabled but, in the absence of the appropriate data, this excursus was the only journey possible in what appears to be, hitherto uncharted waters.

It would be unduly credulous to believe that inappropriate use of antipsychotics in mental hospitals is restricted to the elderly and the intellectually challenged. But there is no need to attempt such feats of imagination because an application of the Precautionary Principle (in the face of the evidence uncovered in relation to the elderly and the intellectual challenged) enables the burden of proof to be reversed and permits the conclusion that:

In the face of convincing evidence of the widespread practice of administering antipsychotics to the elderly and to the intellectually disabled, in the interests of others and as a 'chemical cosh', the Precautionary Principle enables the conclusion to be drawn that – in the absence of compelling evidence to the contrary – the practice is generally widespread amongst those subjected to coercive psychiatric treatment.

Section D: Section A principles vs. Sections B and C conclusions: congruence or conflict?

This chapter began by analysing the maxim '*Primum non nocere*' and by then identifying some of the ethical principles that should govern the coercive administration of psychiatric treatments. Two such principles were first identified:

- (i) that the primary obligation placed on a psychiatrist is to do no harm,

(ii) that the psychiatric assessment of benefit or detriment must be securely grounded in evidence-based studies.

The latter was necessary because (as was shown):

- psychiatric clinical judgements were susceptible to a range of cognitive biases which made them unreliable,
- psychiatrists tended to grossly underestimate the likelihood of their proposed treatment causing harm and when such harm was caused, to be reluctant to acknowledge its existence.

The fact that, in any particular case, a psychiatrist believes himself to be acting solely in the best interests of a subject does not, of itself, guarantee that these two principles are satisfied.

The concern of the present chapter was with coercive treatment undertaken in the interests of the subject; for convenience of exposition a conclusion from Chapter 6 (which deals with interventions grounded in the dangerousness of the subject) was anticipated which was to the effect that whilst an assessment of dangerousness might justify a coercive intervention, detention and physical restraint it did not justify coercive ‘treatment’ or chemical restraint other than in cases of an emergency. This enabled a third principle to be formulated:

(iii) The decision to coercively administer psychiatric treatment (as distinct from detention) must be grounded solely on an assessment of the interests of the subject.

The harms which may be occasioned by psychiatric treatment have been broadly classified into two categories:¹⁹⁷

- those physical harms such as diabetes or tardive dyskinesia,
- those harms which strike at the innermost nature of an individual.

In the remainder of the discussion the harms spoken of were of the first type *i.e.* those normally spoken of as adverse effects of medication.¹⁹⁸

The remaining sections of the chapter then examined whether these three principles for governing the coercive administration of psychiatric treatment, were honoured in practice; Section B was concerned with the first two and Section C with the third principle.

¹⁹⁷ See the discussion at the beginning of Appendix I.

¹⁹⁸ Harms of the second type are the focus of Chapter 7.

Section B.1 examined the general question as to the extent to which the treatment decisions made by clinical psychiatrists were grounded on evidence-based studies. The number of studies which had examined this question were few and had concluded that approximately half of such decisions were evidence-based but the standard used in assessing the robustness of an ‘evidence base’ was far from onerous.

Section B.2 examined the robustness of supposed evidence-based studies and showed that many such studies were severely compromised either for theoretical or practical reasons. [The distorting influence of pharmaceutical industry funding, on psychiatric research and clinical practice was discussed in Appendix J.]¹⁹⁹

Whilst these findings undermined the claims of psychiatry to be an evidence-based discipline they did not directly address the robustness of the evidence base for psychiatric treatments which were administered coercively. This problem was addressed in two ways: by examining the robustness of the evidence base, and the responsiveness of psychiatrists (as manifested in their prescribing habits) to authoritative challenges to hitherto accepted beliefs, in relation to antidepressants and antipsychotics. The reasons for choosing these two categories were as follows:

Antidepressants: In that these are the most widely used psychiatric medication, the standard of research into their efficacy and safety serves as a touchstone for the standard to be expected to prevail in relation to the evidence base for other pharmaceutical psychiatric treatments and, in particular, pharmaceutical psychiatric treatments administered coercively.

Antipsychotics: in that these are the standard treatment for schizophrenia and because (as has been argued in Chapter 4) schizophrenia serves as a surrogate for those psychiatric conditions which commonly precipitate a coercive intervention, the robustness of the evidence base for antipsychotics serves as an indicator for the robustness of the evidence base for general coercive pharmaceutical psychiatric treatments.

The conclusions drawn in relation to antidepressants [Appendix K] and antipsychotics [Appendix L] were that the supposed evidence-based studies supporting the use of such drugs were not only deeply flawed but that compelling evidence existed that data concerning the harm caused by these drugs had been actively concealed by the pharmaceutical companies.

¹⁹⁹ The importance of the ability to have unfettered access to the Irish courts to seek redress for harm due to psychiatric intervention was highlighted by the fact that many of the abuses just mentioned, came to light only by virtue of US court proceedings.

Furthermore clinical psychiatrist practice in relation to these drugs did not change in the face of authoritative evidence that earlier beliefs into their safety and efficacy had been deeply flawed – a finding which is difficult to reconcile with the psychiatric tenet that the refusal to change a strongly held belief in the face of compelling disconfirmatory evidence is a criterion for delusion. This refusal by psychiatrists to review deeply held beliefs is also exemplified by the unwillingness of the profession to permit studies into drug-free management of schizophrenia despite the known serious, and sometimes fatal, effects of drug treatment and the promising results of the few studies that have taken place into drug-free treatment.²⁰⁰

The conclusion to be drawn is that, generally speaking, clinical psychiatry does not honour the first and second ethical principles outlined above.

Section C was concerned with whether the third and final principle was honoured in clinical psychiatry and – because of the difficulty of scrutinising antipsychotic use in general psychiatric hospitals – took as examples the use of antipsychotics in the management of the elderly and the intellectually disabled.

It found that the use of antipsychotics for non-therapeutic reasons was not only widespread but harmful and that despite knowledge of the harm caused, psychiatrists were unwilling to change their prescribing habits. The Precautionary Principle enabled the conclusion to be drawn that in the absence of compelling evidence to the contrary, it should be assumed that the use of antipsychotics as a ‘chemical cosh’ was widespread in the mental health system and that psychiatrists – in that they were amenable to being pressured to accede to the interests of others (*e.g.* family or care home management) even in circumstances where these were contrary to the interests of their patient – were not effective custodians of a subject’s interests.

In summary, this chapter posed the question as to whether coercive psychiatric treatment decisions were rigorously grounded in evidence and focused solely on furthering the interests of the subject. Whilst in individual cases the answer is undoubtedly a ‘Yes’, when considered generally both questions must be answered with a resounding ‘No’ for reasons exemplified by quotations taken from earlier in this chapter (and from Appendices K and L):

²⁰⁰ See, for example, Bola (2006b) which is discussed in Appendix L.

The supposed evidence base for psychiatric decision making

The lack of depth of clinical psychiatry's allegiance to the scientific method and the rigorous assessment of evidence can be gauged from :

- (i) those studies on (especially atypical) antipsychotics which laid bare the paucity and weakness of the evidence which had supposedly sustained psychiatry's "previously held certainties";²⁰¹
- (ii) psychiatry's dismissive response (as evidenced in its refusal to change clinical practice) to those studies which challenged the safety and efficacy of atypical antipsychotics.

The plaintiff cry "*How were we so misled?*" was answered by Peter Jones – the lead author of CUTLASS 1 (*supra*) – who stated: " 'Duped' is not right, ... We were beguiled. ... Why were we so convinced? ... I think pharmaceutical companies did a great job in selling their products.... " ²⁰²

A *Lancet* editorial waxed more lyrical:

...[this] is now, and only now, seen as a chimera that has passed spectacularly before our eyes before disappearing and leaving puzzlement and many questions in its wake.²⁰³

Such responses provide eloquent testimony to the fact that it was not the results of rigorous scientific experiment but the marketing ploys of pharmaceutical companies that won the allegiance of clinical psychiatry over the last 20 years. Jones' implicit admonition:

Sometimes the compass tells you go straight in front of you, but you somehow know it is wrong and that north is behind you ... I have learned to follow the compass.²⁰⁴

had (and has) clearly not been taken to heart by his clinical psychiatric colleagues.

Psychiatrists: as sometime custodians of a patient's interests

The depth of clinical psychiatry's allegiance to defending the interests of its patients against the trespass of others, can be gauged from Ballard's (2005) comments that:

Given the often catastrophic effects of treatment, in the context of dementia, it is difficult to see how neuroleptic treatment can be in the best interests of anyone other than the harassed doctor making the prescription.²⁰⁵

²⁰¹ Rosenheck (2006), p.1075 (*supra*).

²⁰² Vedantam (2006) (*supra*).

²⁰³ Tyrer & Kendall (2009) (*supra*).

²⁰⁴ Vedantam (2006) (*supra*).

²⁰⁵ Ballard (2005) (*supra*).

To end the chapter at this point would be to end on a pessimistic note; however a case history taken from Browne (2008) points to a more optimistic way forward. Browne tells of how, in retirement, he had been approached by a family friend in connection with a young 16 year old girl who was in difficulties. The girl's family had recently moved house and she had changed school and was feeling somewhat isolated. The parents went for a long weekend to London and by the time they returned the girl had become "*floridly psychotic*". Before contacting Browne, the girl had been referred by her GP to another psychiatrist:

... the psychiatrist said she was one of the sickest girls she had ever seen and that she should be hospitalised immediately. Had this happened, she would then have been heavily medicated and almost certainly retained for several weeks or months, ... By that time she would have been well on the way to becoming a chronic schizophrenic. I have seen this outcome so many times in the past.²⁰⁶

Unwilling to take that advice the girl's family subsequently brought the girl to Browne who continues:

When I saw her she ... was laughing one minute and crying the next, clearly hallucinating, ... I prescribed a moderate dose of one of ... antipsychotics ... for one week and asked her parents, as soon as she showed some improvement, to ground her with a programme of swimming, walking and healthy living. When I saw her a week later she was together enough to reduce the medication and, within two weeks of my first seeing her, she was back in school and the medication could be discontinued. She has had no further difficulties.²⁰⁷

The lesson that Browne drew from the experience was that schizophrenia was to a considerable degree attributable to the psychiatric intervention itself.²⁰⁸

In drawing the conclusions for this chapter the problem that has to be resolved is to determine how to best ensure that in a similar situation, the most minimal therapeutic intervention is permitted rather than allowing the alternative outcome – such as that envisaged by Browne of a diagnosis of schizophrenia precipitating a lifetime use of antipsychotics with all the attendant stigma – to unfold.

A solution is to hand: the implementation of a system of judicial review of proposed coercive psychiatric treatment decisions (other than those concerning emergency short term restraint), undertaken by a court which will not genuflect in the face of psychiatry's self proclaimed 'certainties' but by adopting a sceptical attitude, subject them to a rigorous scrutiny. It was the availability of such a system that enabled the *Bigley* and *Starson* cases (*supra*) to be adequately resolved and it is only the implementation of such a system that will help ensure that the outcomes as portrayed by

²⁰⁶ Browne (2008), p.326.

²⁰⁷ *Ibid.*

²⁰⁸ See the Introduction for a more complete statement of his views.

Browne, are not chosen simply because of a judicial inertia arising from an unwillingness to critically examine psychiatry's orthodoxies.

The unfettered access to the courts for those who have been harmed by coercive psychiatric intervention would be a further safeguard and would indirectly ensure that (what has hitherto not been the case) full and adequate records of all psychiatric treatments especially those relating to coercive psychiatric interventions, be maintained. The existence of such records allied to a judicial oversight, would also permit the implementation of a full and complete audit of the extent of iatrogenic harm consequent on psychiatric intervention.

A related conclusion concerns the necessity of permitting research into drug-free and minimal drug therapies in the management of schizophrenia especially in that drug-free therapies have proved superior to the use of antipsychotics in relation to the management of the elderly and the intellectually disabled and have shown promise in the management of schizophrenia.

Chapter 6: *Psychiatric assessments of dangerousness*

*My Life had stood – a Loaded Gun -
In Corners – till a Day
The Owner passed – Identified -
And carried Me away –*

Lines from a poem by Emily Dickinson.¹

As outlined in the Introduction, the argument being advanced in this dissertation is divided into three stages:

Stage 1: examines coercive psychiatric interventions undertaken solely in the interests of the subject;

Stage 2: examines coercive psychiatric interventions undertaken solely in the interests of others;

Stage 3: examines coercive psychiatric interventions undertaken on mixed grounds – *i.e.* both in the interests of the subject and in the interests of others.

Earlier chapters have examined aspects of the Stage 1 argument; the task of the current chapter is to examine that aspect of the Stage 2 argument which is additional to the Stage 1 argument, namely ‘dangerousness to others’; consequently the ‘dangerousness’ referred to in the chapter title relates to ‘dangerousness to others’ and not to ‘dangerousness to self’ (*e.g.* a risk of self harm or suicide) which falls under the Stage 1 argument. It is of note that some academic psychiatrists have argued that dangerousness criteria should no longer fall under the purview of mental health legislation.²

The Stage 3 argument will be addressed in the dissertation conclusions and its resolution will be based on the conclusions drawn concerning the Stage 1 and Stage 2 arguments.

Dangerousness: imminent vs. predicted

The ‘assessments of dangerousness’ spoken of above refers to future predictions of dangerousness and not assessments of imminent danger.

¹ Dickinson [McNeil (ed.)] (1997), p.73.

² Large (2008), for example, argues (p.877) that “*Dangerousness criteria should be removed from mental health legislation and be replaced by criteria that focus on a patient’s capacity to refuse treatment*”; he also contends that “... *the dangerousness criterion is unnecessary, unethical and [may be] ... potentially harmful to mentally ill people and to the rest of the community.*” and that “*Dangerousness criteria unfairly discriminate against the mentally ill.*”

Consider the scenario mentioned in the Introduction: a man runs down a crowded street, shouting wildly and brandishing a knife; such a scenario clearly portrays an individual who presents an imminent danger to others and it is clear that the individual needs to be restrained or subdued until a more considered solution be arrived at. The temporary restraint of such an individual presents no particular ethical problems nor does the choice between physical restraint (*e.g.* the use of handcuffs by police or psychiatrists) or a chemical restraint (*e.g.* the use of a gas spray by police, or of a psychoactive drug, by psychiatrists).

However, whilst the ethical distinction between the use of a physical or chemical restraint may not be of importance when considered as a temporary response to an emergency situation, it is of importance when the duration of the restraint is prolonged (*e.g.* restraint lasting weeks or months) because of the especially damaging effects of some chemical restraints (or ‘treatments’) – such as, for example, antipsychotics – on personhood.³

Problems concerning psychiatric assessments of dangerousness have been touched on earlier⁴ and a brief review is given in *Section A* which helps provide a context for the discussion to follow.

A deep mismatch exists between assessments of the link between mental illness and dangerousness as perceived by the popular media, and as determined by research studies; the media portrays the link as unequivocal and strong, whereas research studies indicate that the link, if not tenuous, is weak. The media perception is important as it can be determinative of political attitudes which may, in turn, influence psychiatric practice.⁵ These issues are discussed in *Section B*.

The links between mental illness and dangerousness (as discussed in Section B) relate to the problem considered in its generality and are of little assistance in resolving the problem faced by clinical psychiatrists, and courts, in determining the risk of dangerousness posed by any one particular individual. Some strategies have been developed by psychiatrists which purport to assist in individual risk assessment, but the reliability of such strategies has been questioned⁶ and the serious ethical problem posed

³ See Chapter 7.

⁴ See especially Appendix F.

⁵ See *infra* and Appendix F.

⁶ *Ibid.*

by the occurrence – and possible prevalence – of ‘false positives’ has often been ignored.⁷ These issues are discussed in *Section C*.

The ethical problems involved in choosing between chemical ‘treatments’ and mechanisms of physical restraint in the management of individuals who present a continuing imminent danger to others, is discussed in *Section D*.

Section A: Some earlier references to assessments of dangerousness

As discussed in Chapter 3, Fulford suggests that ‘*The Othello Syndrome*’⁸ is:

... important, with compulsory treatment in mind, because it is one of the few psychiatric conditions known to be definitely associated with an increased risk of homicide.⁹

In the context of the present chapter, such a definitive statement, by an academic of such eminence in the philosophy of psychiatry, calls for a close examination of the evidence cited in its support. [*Subsection A.1*]

Examples of individuals who have legally challenged their coercive psychiatric treatment have been given earlier; in such cases the psychiatrist’s belief that coercive treatment is necessary because of the ‘dangerousness’ of the subject, is occasionally challenged and – though it may well be imagined that the term ‘dangerous’ is clear and unambiguous – these examples show that sometimes the psychiatric use of the term is, at best, unconventional. [*Subsection A.2*]

A consideration of such examples is important because psychiatric assessments of dangerousness are often not subjected to critical scrutiny and may be accepted at face value.

A.1: Fulford and the risk associated with morbid jealousy

Fulford, as authority for his assertion (*supra*), cites a single reference¹⁰ dating from 1967 and entitled *Uncommon Psychiatric Symptoms*; one such symptom is ‘*The Othello Syndrome*’.

⁷ See, for example, Maden (2003a).

⁸ *I.e.* morbid jealousy

⁹ Fulford (1989), p.204.

¹⁰ Enoch (1967).

A.1.1: Enoch: The Othello Syndrome

Enoch discusses the manifestation of this syndrome in myth and literature and gives an account of its psychological origins which is, at times, highly speculative.¹¹ He notes the long standing association of morbid jealousy with alcoholism.¹²

Enoch unequivocally asserts the strength of the link between morbid jealousy with violence on a number of occasions:

(i) This syndrome has extensive and severe social ramifications. ... Again, contrary to most psychiatric illnesses, this is a dangerous condition which does lead in some cases to homicide and suicide.¹³

(ii) Contrary to popular belief, most psychiatric illnesses do not necessarily lead to violence. Psychotic jealousy is an exception. Shepherd has dealt with the forensic aspects of delusional jealousy in some detail, confirming that it constitutes a well-established motive for crimes of violence, particularly against the spouse.¹⁴

(iii) Some cases persist in spite of all therapy, and, in view of the real homicidal threat to the wife, hospitalization, often under compulsory order, becomes imperative.¹⁵

Enoch provides little to substantiate his assertions concerning the supposed link between morbid jealousy and dangerousness other than the single reference (*supra*) to Shepherd (1961) and some case studies which are of only anecdotal value; he provides no original data.

A.1.2: Shepherd: The forensic aspects of delusional jealousy

Shepherd (1961) provides a scholarly account of the phenomenon of jealousy ranging from its etymology to the problem of its philosophical definition;¹⁶ to its link with drug

¹¹ According to Enoch, the syndrome “*may specifically be linked*” with a threat to what the husband perceives to be his “*property*”, and:

... Secondly, the central inadequacy may be linked with the patient’s own illicit desires to be unfaithful, which are in turn projected on to the spouse.

... Thirdly, the inadequacy which is projected may reveal itself as a propensity towards homosexuality. ... (pp.43-4)

¹² *Ibid.*, p.39:

Accounts of morbid jealousy abound in the psychiatric literature, though it is mostly associated with paranoid states and alcoholism. Up to the turn of the century, it was nearly always regarded as is being associated with alcoholism.

The link between alcoholism (and substance abuse) and dangerousness has been the subject of much research [see Section C *infra*]. The Irish *Mental Health Act* (2001) S.8 (ii) specifically precludes drug or alcohol addiction being grounds for involuntary committal [see Appendix A].

¹³ *Ibid.*, p.37.

¹⁴ *Ibid.*, p.42.

¹⁵ *Ibid.*, p.47.

¹⁶ Though his discussion is less than rigorous; see, for example (p.687):

Even the most celebrated definitions – Descartes’ “*kind of fear related to a desire to preserve a possession*” or Spinoza’s “*mixture of hate and love*”, for example - merely illustrate the complexity of a term whose many nuances of meaning can be detected in its roots.

addiction¹⁷ and alcoholism¹⁸ – a theme which dominates the paper. He acknowledges the difficulty in distinguishing between ‘normal’ and ‘abnormal’ jealousy¹⁹ and discusses the link between abnormal jealousy and schizophrenia²⁰ and the presence of paranoid ideas such as:

... the belief that the suspected person has been giving the patient substances for the purpose either of poisoning him or of impairing his sexual potency; suspicions that the partner is suffering from venereal disease or has been indulging in sexual intercourse with a third person during the patient's sleep;²¹

Such scenarios are far removed from those portrayed by Fulford (*supra*)²² which consisted simply of an individual presenting with a delusional²³ (but true) belief that his wife was being unfaithful and which – by virtue of his continued insistence in maintaining his belief despite his inability to justify it – became a candidate for coercive psychiatric detention.

As has been seen above, Enoch (1967) – whom Fulford cited as his sole authority – provided little support; does Shepherd (1961) – whom Enoch cited – provide any more substantial grounds?

Shepherd (1961) in his discussion of forensic aspects of morbid jealousy, cites a number of studies which sought to determine the proportion of convicted murderers who had been motivated by sexual jealousy, for example:

(i) ... over a two-year period 54 out of 760 murders in Cook County, Illinois, were due to jealousy ...

(ii) Mowat has examined the records of the male and female patients admitted to Broadmoor during periods of 20 and 15 years and has found morbid jealousy to have been a significant factor in 12 per cent and 15 per cent respectively.²⁴

As discussed in detail in Appendix F, such studies (and some similar, more modern, studies²⁵) may, ideally, assist in calculating the probability of whether a convicted murderer had delusions of jealousy but this is not the problem faced by a clinical

¹⁷ Shepherd (1961), p.691: “*Kraepelin regarded cocaineism as one of the conditions most intimately associated with morbid jealousy.*”

¹⁸ *Ibid.*: “*Alcoholism constitutes the most widely recognized physical association of morbid jealousy.*”

¹⁹ *Ibid.*: “*The borderline between such reactions and those of the ‘normal’, understandably jealous individual remains arbitrary in the present state of knowledge.*”

²⁰ *Ibid.*, p.693: “*Morbid jealousy with delusions of marital infidelity constitutes a well recognized symptom-complex in schizophrenic illness.*”

²¹ *Ibid.*, p.690.

²² See also Fulford (2006) [this example was discussed more fully in Chapter 3]:

Mr O.S. ... Attended general practitioner’s surgery with his wife who was suffering from depression. On questioning, delivered an angry diatribe about his wife being ‘*a tart*’. Unable to talk about anything else. Offered unlikely evidence (*e.g.* pattern of cars parked in road). Psychiatric referral confirmed diagnosis even though the doctors concerned knew that Mrs. O. was depressed following the break up of an affair .. (p.43).

²³ See Chapter 3.

²⁴ Shepherd (1961), p.699.

²⁵ *E.g.* Muzinić (2003).

psychiatrist (such as in Fulford's example) who, faced with a subject who is morbidly jealous, seeks to determine the likelihood that the subject will become violent. It is, in fact, the obverse problem and any attempt to apply the results of studies of the former problem to the latter are guilty of making a fundamental error of probabilistic reasoning.²⁶

The clinical psychiatrist needs to know the probability that an individual who is morbidly jealous will become dangerous; knowledge of the probability that one who is, or has proved to be, dangerous (*e.g.* is a convicted murderer) had morbid jealousy is of little relevance especially in circumstances where the incidence of morbid jealousy in the general population is unknown.²⁷ Consequently these studies do not substantiate Fulford's original assertion.

However Shepherd (1961) does discuss a further study [Kolle (1932)]²⁸ which is relevant to Fulford's assertion. Kolle (1932) took as his sample population a group of morbidly jealous alcoholics and followed their progress over a period of between five and twenty two years. The only manifestation of violence or dangerousness in these subjects during that period was the suicide of one of their number – a result which radically undermines Fulford's contention. Indeed rather than being an advocate for proactive coercive psychiatric detention, Shepherd embraces the possibility that the problem of morbid jealousy might be resolved through non-medical agencies²⁹ or marital separation.³⁰

In summary, Fulford's (1989) contention that a morbidly jealous subject is pre-eminently suitable for coercive psychiatric detention and treatment because their

²⁶ The confusion of these two problems – *i.e.* the probability of A (given that B is true) [P(A|B)] and the probability of B (given that A is true) [P(B|A)] – is known as the '*base rate error*' and its occurrence in what purports to be a statistical analysis, is so grievous as to fatally undermine the analysis. [The '*base rate error*' is discussed more fully in Appendix F].

²⁷ Kingham & Gordon (2004), p.207:

The prevalence of morbid jealousy is unknown, as no community survey exists. It has been regarded as a rare entity (Enoch & Trethowan, 1979), but most practising clinicians encounter it not uncommonly.

²⁸ Shepherd (1961), p.692:

The most careful and satisfactory study, however, is that of Kolle who ... distinguished clinically between three principal subgroups; ... The long and careful follow-up of his cases gives force to Kolle's views.

Kolle, K.(1932). 'Über Eifersucht und Eifersuchtswahn bei Trinkern.' *Monatsschr. f. Psychiatrie u. Neurol.* 83, 128.

²⁹ *Ibid.*, p.698:

... the lawyer, the policeman, the probation officer, ... or the marriage guidance counsellor ... Intervention of these non-medical intermediaries may not only determine referral to a physician; when effective it can dispense with the need for medical assistance or advice in an incalculable but probably large proportion of cases.

³⁰ *Ibid.*, p.702: "... the desirability of a temporary or permanent separation which can so often bring about a subsidence of the turbulent emotions."

condition: “... is one of the few psychiatric conditions known to be definitely associated with an increased risk of homicide” is not supported by the authorities which he cited and – as will be seen *infra* – is indicative of a general absence of rigor in discussions of dangerousness in the context of coercive psychiatric intervention.

A.2: Some examples of psychiatric assessments of dangerousness

The examples to be discussed are the Manweiler and Bigley cases.

A.2.1: Manweiler’s dangerousness

The background to the Manweiler case³¹ concerned family disagreements about the execution of a will and involved a son – who was in dispute with his married sister – and who was living with his aged mother who had dementia. The immediate circumstances precipitating the problem, was a verbal altercation between Manweiler and his mother; the mother became distressed and relayed her distress to Manweiler’s sister who, in turn, insisted that Manweiler seek admission to a mental hospital as a voluntary patient. Shortly after admission his status was changed to ‘involuntary’ because, as stated by his psychiatrist in a subsequent court case:

... he was constantly grumbling about being there and was without enthusiasm. There was a serious history of violence that came from the evening before when his mother left the house. ... it was for safety’s sake that this had to be done.³²

Under cross examination considerable doubt was cast on the psychiatrist’s assertion of the existence of a “*serious history of violence*”; and – in that the jury not only fully accepted Manweiler’s account of events but also penalised the defendants for the manner in which they had attempted to justify their behaviour – it can be concluded that, whilst Manweiler may have spoken aggressively to his mother thus causing her to become distressed, no act of violence had taken place.

In the absence of court proceedings, Manweiler’s file containing the damning phrase that he had “*a serious history of violence*” would have continued unchallenged and unchallengeable and would constitute the basis on which any subsequent ‘risk assessment’ of Manweiler’s level of dangerousness would be calculated.

A.2.2: Bigley’s dangerousness

The Bigley case³³ arose out of an application to the Canadian courts by a hospital psychiatrist that Bigley be subjected to coercive psychiatric detention and treatment because of his dangerousness.

³¹ Appendix H is devoted solely to a discussion of the Manweiler case.

³² Browne (2005b).

In justification of his assessment the psychiatrist stated, *inter alia*, that Bingley:

... was in grave danger because he might irritate other people, including police officers, to the point where he might end up being hurt. “*He’s very inappropriate,*” Dr. Raasoch said. “*He gets up in people’s faces. I think the majority of people would just punch him.*”³⁴

In the event the psychiatrist’s assessment of dangerousness was not accepted by the court, but in the absence of an obligation to seek court approval for coercive psychiatric detention (a legal requirement in Canada but not in Ireland) there is little doubt but that the psychiatrist assessment of dangerousness would have remained unchallenged.

It is of interest to apply the test used by the psychiatrist, to some alternative scenarios:

- a vociferous civil rights activist in the southern United States in the mid 1960s would undoubtedly also have posed a grave danger of irritating others to the point at which they may well have responded violently;
- a political dissident in the former USSR who championed free market capitalism would also be likely to ‘*get up in people’s faces*’ and be ‘*punched*’.³⁵

A consideration of such scenarios shows clearly that highly inappropriate criteria were being employed in the psychiatric assessment of dangerousness.

Section B: Mental illness as a predictor of dangerousness?

The media portrayal of the link between mental illness and dangerousness is discussed in *Subsection B.1*; examples of the effects of such portrayal on political opinion are given in *Subsection B.2*.

Some research studies which have examined the nature and extent of the links between mental illness and dangerousness, are discussed in *Subsection B.3*.

Some conclusions are drawn in *Subsection B.4*.

B.1: As perceived by popular media

Speaking in the House of Commons debates on the *Mental Health Bill* (2007), Mr. Charles Walker MP, gave some examples of press reportage linking mental illness and dangerousness:

I did some research; the *Daily Mail* had the headline: “*Knife maniac freed to kill. ... Mental patient ran amok in the park*”, while *The Sun* had “*Violent, mad. So docs set him free. New community care scandal.*” ...

³³ See Chapter 5.

³⁴ Berenson, A. (2008b). ‘One Drug, Two Faces.’ *The New York Times*. 25 March.

³⁵ See the case of Leonid Plyushch which is discussed *supra*.

They are appalling misrepresentations of people with mental illness, and it does our media a great disservice that they persist in bringing them forward.³⁶

These are not isolated examples nor are they confined to the UK media; Thornicroft (2006) – in his study on discrimination against people with mental illness – summarises the results of some studies on the media portrayal of mental illness in relation to perceived dangerousness:

(i) A one month monitoring of all New Zealand newspaper stories which referred to mental illness [Coverdale (2002)] found that:

In results closely similar to an earlier Australian study, more than half of all the items depicted the mentally ill person as dangerous, and the key themes that emerged were danger to others (61 per cent), criminality (47 per cent), unpredictability (24 per cent) and danger to self (20 per cent). Most of these newspaper stories used undifferentiated terms such as ‘*psychiatric patient*’ or ‘*mentally ill*’.³⁷

(ii) A study [Corrigan (2005)] of over 3,000 newspaper stories about mental illness which were published in the US found that:

... most often the stories focused on dangerousness and violence, often in front page stories (39 per cent) ... Interestingly this systematic tendency to highlight violence above all other aspects of mental illness was described by the authors as ‘*structural discrimination*’, ...³⁸

(iii) Studies in relation to television coverage, found comparable results:

In one of the most detailed of these evaluations, a Glasgow Media Group in Scotland analysed one month’s output for national and local television, the press and magazines, including all content ... The authors summarized by saying that “*the bulk of media content situates mental illness in a context of violence and harm ... such representations can clearly affect audiences*”.³⁹

A content analysis of prime-time television in the USA concluded that mentally ill characters were nearly 10 times more violent than the general population of television characters, and 10 to 20 times more violent ... than the mentally ill in the US population ... In the US 73 per cent of peak-time television characters with mental illness were shown as violent individuals.⁴⁰

Thornicroft (2006) concludes that such a predominant concern with violence is found repeatedly in such studies:

Overall it seems that the pattern we saw in newspaper coverage, that between a half and three-quarters of all items about mental illness focus solely on violence, is repeated in television programmes.⁴¹

The studies also found that such portrayals were deeply influential in the moulding of public opinion:

³⁶ Hansard (2007). *House of Commons Debates*. 463 (124): Column 116-117, 16 April.

³⁷ Thornicroft (2006), p.109.

³⁸ *Ibid.*, p.110.

³⁹ *Ibid.*, p.113 citing as reference Philo, G. (1996). (ed.). *Media and Mental Distress*. London: Longman.

⁴⁰ *Ibid.*, citing numerous references.

⁴¹ *Ibid.*, p.114.

Work in the USA found that 87 per cent of people said that television was one of their main sources of information. Compared with 51 per cent from friends and 29 per cent from medical professionals.⁴²

B.2: Political responses to the media portrayal

Mr. Walker MP (*supra*) – alluding to the danger of politicians “*pandering to the tabloid press*” – stated that: “*It appears that a different set of rules apply to the mentally ill – that the normal rules relating to limiting civil liberties and rights are suspended.*”

In response to an article in *The Daily Telegraph* – which urged MPs that: “*If this Bill will save lives, then Parliament has a duty to support it.*” – Waker continued:

I can think of a couple of Bills – unattractive Bills – that might save lives ... We could introduce a Bill to ensure that people with AIDS are locked up so that they do not pose a public risk. That would be unattractive, but I am sure that it would save a few lives. We could go out and round up young black males in Peckham, which might save a few lives in that area, but that is an unattractive and unpalatable solution. So why is it that when we discuss mental health we too often separate sufferers from everyone else to whom we accord rights?⁴³

Lord Bragg, speaking on the Bill in the House of Lords, acknowledged the possibility that the government had yielded to media pressure:

It would be cowardly of the Government to allow its policy to be driven by tabloid hysteria about the very, very rare, though of course deeply regrettable, incidences of murder and assault committed by people with severe mental health problems.⁴⁴

Indeed the original Bill had been drafted to reflect public concerns as reflected in the popular media: the Bill, as first tabled, had proposed that coercive psychiatric detention be permissible on grounds of dangerousness even in the absence of any therapeutic benefit⁴⁵ – a proposal which was dropped⁴⁶ following widespread criticism by medical organisations and civil liberties campaigners.

Amongst academic psychiatrists, there is also support for the view that the linking in the public mind of violence and mental disorder, is a prime motivating force for legislation

⁴² *Ibid.*

⁴³ The question implicitly posed by Mr. Walker (*i.e.* why is it permissible to coercively detain members of one group of individuals on the grounds of their dangerousness but not members of another who pose a possibly greater risk of violence) is of profound importance and will be discussed later in this chapter.

⁴⁴ Owen, J. & Goodchild, S. (2007a). ‘Lord Bragg attacks Mental Health Bill as “*inhumane, inefficient and unfair*”.’ *The Independent*. 22 April.

⁴⁵ Goodchild & Woolf (2007b):

Ministers have insisted it is necessary to get people with severe disorders off the streets, even if there is no treatment available. This has been a major source of opposition – especially from psychiatrists, who believe they will be turned into jailers.

Goodchild, S. & Woolf. (2007b) ‘Insane! Stop the Mental Health Bill.’ *The Independent*. 15 April.

⁴⁶ See, for example, Bamrah (2007):

Previous Bills advocated that appropriate treatment could be given even where there would be no defined therapeutic benefit. It is a shame that the government had to be dragged into making a concession on what is the most crucial aspect of why any patient is detained, other than safety.

in this area and, consequently, for psychiatric practice.⁴⁷ Indeed some academic psychiatrists argue strongly that psychiatry should – in its own professional interest – actively seek to accommodate (rather than address⁴⁸) the concerns of both the public and the politicians; Maden, for example, who holds a position of some eminence in British psychiatry,⁴⁹ states, in an editorial, that:

The College⁵⁰ is right to be concerned about stigma, but it is arguable that the profession is now more stigmatised than the patients. Like the rest of life, none of this is fair. Both the government and the public overestimate the risk of violence by psychiatric patients. Tabloid editors overstate the risk in order to sell newspapers. But, crying foul and complaining about stigma will not win back the public confidence in mental health services that our patients need. ... The lesson for general psychiatry is that, once the public and politicians have made violence a major issue, services need to be seen to be taking it seriously.⁵¹

B.3: Academic Research

Lest it be assumed that definitive results on the linkage between dangerousness and mental disorder are readily available, a cautionary note is in order:

Unfortunately what research questions are asked, what methodologies applied and how results are interpreted are all open to profound influence by the prior commitments of researchers.⁵²

Thornicroft (2006) also urges that in interpreting such research studies “*we need to tread with care;*”⁵³ and he lists a number of possible complications to be borne in mind:

- the data should relate to actual violent events rather than crimes,⁵⁴
- all characteristics of the incident should be noted *e.g.* alcohol or drug use and not just mental disorder; similarly, the presence of social factors such as unemployment,⁵⁵

⁴⁷ Steadman (1998), p.393:

The public perception that mental disorder is strongly associated with violence drives both legal policy (*e.g.*, civil commitment) and social practice (*e.g.*, stigma) toward people with mental disorders.

⁴⁸ Butcher (2007):

“*It is not enough really for the College to say ‘well it’s pretty rare when somebody gets killed by a patient’. I think it is such an unacceptable risk that even at that low level we need to take on board how it is viewed by the public*”, says Maden.

[‘Maden’ refers to Professor Anthony Maden; ‘College’ refers to the Royal College of Psychiatrists.]

⁴⁹ Professor Anthony Maden is Professor of Forensic Psychiatry at Imperial College, London.

⁵⁰ *I.e.* the Royal College of Psychiatry.

⁵¹ Maden (2005), p.121.

Maden (2001) also stated [see also Appendix F]:

... concern about violence dominates the thinking of politicians in this area. It is unlikely that they are going to lose votes by overstating the level of risk associated with psychiatric patients, so the profession is going to have to come up with something better than bland reassurance.

⁵² Mullen (2001), p.4; see *infra*.

⁵³ *Op. cit.*, p.127.

⁵⁴ Thornicroft (2006) argues that restricting the data to actual crimes would tend to underestimate the prevalence of violence; against this it may be argued that using ‘*actual violent events*’ risks compromising the objectivity of the assessment of the actual degree of violence.

- the possession of a psychiatric history should be distinguished from the contemporaneous exhibiting of a mental disorder; furthermore, the category ‘*mentally ill*’ is too general to be useful and requires refinement.
- it is necessary to distinguish between ‘*relative risks*’ and ‘*absolute risks*’.⁵⁶

As suggested by Mullen (*supra*), the perspective that is implicitly adopted can influence how ‘dangerousness’ is discussed; some remarks on differing perspectives are made in B.3.1; some of the more important research findings are discussed in B.3.2.

B.3.1: Differing perspectives towards dangerousness

Butcher (2007) describes how the psychiatric perspective on the link between mental illness and violence has changed over recent decades:

When the *Mental Health Act* was introduced in 1983, psychiatrists believed that there was no association between mental illness and violence. ... it was Jonathan Zito’s murder⁵⁷ ... that changed the practice of psychiatry in the UK, according to Anthony Maden, ... “*The way that we do psychiatry in 2007 is almost unrecognisable from the way it was in 1983. In 1983 we did not know about those risks and now not only do we know about them, but the government has been forced to take them very seriously*”, says Maden.⁵⁸

Maden credits the change in the psychiatric perspective on dangerousness both to political pressure and to the results of academic research. Mullen (2001), in contrast, credits the change to a move by academic psychiatry, from sociological models of mental illness to biochemical models.⁵⁹

It is important that this change in perspective be made explicit because it deeply influences how the term ‘dangerousness’ is understood: implicitly adhering to the

⁵⁵ *Ibid.*, p.127:

... we know that at least half of all people with a mental illness receive no treatment, and people who are violent and mentally ill are more likely to be treated. Therefore studies of people with treated mental illness will show artificially high rates of violence compared with rates for all people with a mental illness, whether treated or not.

⁵⁶ ‘*Relative risks*’ measures how much more often people with a particular condition may commit violent acts than those without this condition; ‘*absolute risks*’ measures the actual number of such incidents or events. [Thornicroft (2006), p.127].

⁵⁷ Butcher (2007), p.118:

On Dec 17, 1992, Christopher Clunis murdered Jonathan Zito, a total stranger who was standing [at a] tube station in London. Clunis had paranoid schizophrenia and ... had been seen by 43 psychiatrists in his [*sic*] last 5 years and frequently moved between different health authorities. “*The mental–health services passed him around — as soon as he was better they kicked him out of the door with no attempt to provide follow-up care — they sent him out with an outpatient appointment*”, says Anthony Maden.

⁵⁸ Butcher (2007), p.117.

⁵⁹ Mullen (2001), p.3:

The enthusiasm for the rediscovered ‘dangerousness’ of the mentally disordered was not shared by all researchers and all disciplines. Sharp divisions on the issue became increasingly apparent. Again the debate was only partly grounded in research data and in part reflected ideological commitments. The mainstream of psychiatry in the 1980’s returned from an emphasis on broadly social and psychological constructions of mental disorder back to its traditional medical adherence to causal theories based in neurobiological pathologies and genetic variations.

biochemical model runs the risk that environmental and sociological factors become obscured and “*dangerousness become reified and this thing attributed to classes of individuals.*”⁶⁰

Mullen (1984) insists that a wider perspective be adopted:

Dangerousness is not a quality of an individual but of an individual’s actions. ... Behind any such definition lurks social and political judgements, just as surely as they lie embedded in our judicial and penal system. In our society, it is the violence perpetrated by the stranger criminal on his fellow citizen which creates the most public concern and fear ... but such crimes inflict less death and destruction than those wrought by the domestic violence of our nearest and dearest ... The danger to the community presented, for example, by the industrialist who ignores safety regulations ... do not even enter into the dangerousness literature.⁶¹

B.3.2: Research Findings

The results of some individual studies on the links between mental disorder and violence are discussed in B.3.2.1.

The literature on the possible relationships between mental disorder and violence is extensive, accordingly authoritative reviews of the literature are of especial interest. Both Thornicroft (2006) (*supra*) and Mullen (2001) (*supra*) have conducted such surveys as has Sirotich (2008) whose review is particularly comprehensive; these are discussed in B.3.2.2.

B.3.2.1: Some individual studies

Steadman’s (1998) study is discussed in B.3.2.1.1.; Fazel’s (2006), in B.3.2.1.2.; and some criticisms of Fazel (2006), in B.3.2.1.3.

Some comments on an analogous problem namely the link between race and violence in the US, are made in B.3.2.1.4.

Buchanan’s (2008) study is discussed in B.3.2.1.5 and Elbogen & Johnson’s (2009), in B.3.2.1.6.

B.3.2.1.1: Steadman (1998)

Steadman (1998) was a follow up study of 1,136 patients with mental disorders who, on discharge from hospital, were monitored during the following year for manifestations of violent behaviour. An interesting aspect of the study was that the control group was chosen from amongst those living in the same neighbourhoods as the discharged

⁶⁰ Mullen (1984), p.9: “*Dangerousness is best left undefined or vaguely delineated as in ‘a propensity to cause serious physical injury or lasting psychological harm (to others)’.*”

⁶¹ *Ibid.*

patients thus equalising the more obvious sociological and environmental factors that might precipitate violent behaviour. The study found that:

There was no significant difference between the prevalence of violence by patients without symptoms of substance abuse and the prevalence of violence by others living in the same neighborhoods who were also without symptoms of substance abuse. Substance abuse symptoms significantly raised the rate of violence in both the patient and the comparison groups, and a higher portion of patients than of others in their neighborhoods reported symptoms of substance abuse.⁶²

In relation to the portrayal of violence and mental disorder in the popular media, it is of interest to note that this study was reported in *The New York Times* under the heading “*Studies of Mental Illness Show Links to Violence.*”⁶³

B.3.2.1.2: Fazel (2006)

Sweden has the largest inpatient hospital register in the world.⁶⁴ It also has comprehensive records of criminal convictions which include crimes committed by those who have been diagnosed as having a psychiatric disorder.⁶⁵ Furthermore each resident in Sweden has a unique identification number and thus a linkage may be established between those who had been inpatients in a psychiatric hospital, and those convicted of a violent offence. Fazel (2006) analysed the data generated by this linkage for the period between 1988 and 2000:

We calculated the population-attributable risk: the number of violent crimes committed per 1,000 persons in the whole population that would *not* have occurred if the risk factor – severe mental illness – had been absent, and the population-attributable risk fraction, which is the proportion of violent crimes in the whole population that may be attributed to individuals with severe mental illness.⁶⁶

The study concluded that in the period studied:

The number of individuals with severe mental illness who committed at least one violent crime over the time period was 6,510. Therefore, of all patients with

⁶² *Op. cit.*, p.393.

⁶³ Butterfield, F. (1998). ‘Studies of Mental Illness Show Links to Violence.’ *The New York Times*. 15 May; the article began:

After a generation of believing that the mentally ill are no more violent than other people, psychiatrists and advocates for the emotionally disturbed are wrestling with studies that show that the mentally ill may indeed be more violent in some circumstances.

... Substance abuse increased the rates of violence by mental patients by up to five times, the study concluded, while it tripled the rate of violence by other people.

⁶⁴ Fazel (2006), p.1398.

⁶⁵ *Ibid.*:

We used conviction data because, in Sweden, in common with only a few countries in the world, individuals with mental disorders who are charged by the courts are convicted as if they did not have mental disorders (*i.e.*, regardless of their mental state at the time of the offense), although sentencing does take mental health issues into account.

⁶⁶ *Ibid.* [Emphasis in original].

severe mental illness, 6.6% had a violence conviction. This compared with ... 1.8% of the general population, who had a violence conviction.⁶⁷

... patients with severe mental illness, as identified by hospital admissions, committed about 5% of all violent crimes.⁶⁸

Fazel acknowledged that his analysis had some limitations⁶⁹ the most serious of which is the presumption of a *causal* relationship between severe mental illness and violent crime.

B.3.2.1.3: Some criticisms of Fazel (2006)

Pinta (2006) points out that Fazel's (2006) methodology may overestimate the linkage between mental disorder and violence;⁷⁰ an observation also made by Sirotych (2008).⁷¹

Buchanan (2008) notes that studies such as Fazel (2006) often do not distinguish between cases where the hospitalisation occurred before or after the act of violence; in such circumstances it is inappropriate to frame the discourse in terms of 'causality'.⁷²

Fazel (2006) is also open to a more serious criticism which may be more easily understood by examining an analogous problem: the link between race and violence or, more specifically, the link between being a black resident of the US and being convicted of a crime of violence, and imprisoned.

⁶⁷ *Ibid.*, p.1399.

⁶⁸ *Ibid.*

⁶⁹ In addition to the presumption of causality, the limitations were:

- individuals with severe mental illness who had not been admitted to hospital;
- individuals who had been convicted prior to hospital admission;
- the use of conviction for a violent offence as a measure of the prevalence of violence results in an underestimation.

⁷⁰ Pinta (2006), p.2193:

At every phase of the criminal-justice process, there are selective factors that determine who are apprehended, arrested, and convicted of criminal offenses. ... Teplin reported that attitudes of arresting officers toward the mentally ill can result in arrest rates that are significantly higher than those for non-mentally ill offenders.

⁷¹ Sirotych (2008), p.179:

For example, most of the birth cohort studies have been conducted in Scandinavian countries that have a low crime rate and relatively uniform prosperity. Given the relatively low crime rate, persons with mental disorder may appear to be at an elevated risk of criminality relative to the general population. However, in countries like the United States, which have high overall crime rates, the relative importance of mental disorder is apt to be understated given that crime is more pervasive.

⁷² Buchanan (2008), p.187: "*The causal implications of symptoms occurring before and after a violent act are obviously different, but methodologies have not always distinguished the two.*"

Fazel (2006), p.1401:

Although it is reasonable to assume that the severe mental illnesses that were included in this study are mostly lifelong, this might overestimate the contribution of severe mental illness to violent crime.

B.3.2.1.4: An analogous problem: race and violence in the US

Statistics on the number of prisoners in State prisons⁷³ in the United States who have been convicted of a violent offence, can be analysed by the race of the offender. An analysis for 2005 shows that there were 687,700 inmates in total of whom 235,800 were white and 275,700 black.⁷⁴ In 2005, the population of the United States was estimated to be 288 million of which 234 million were whites and 37 million were black.⁷⁵ Thus, although blacks comprise roughly 12.5 % of the population, they represent about 50% of those in State prisons having been convicted of a crime of violence.

The overrepresentation of blacks amongst those imprisoned for a violent offence in US State prisons is considerably greater than the overrepresentation of ex-psychiatric patients imprisoned⁷⁶ for a violent offence in Sweden; hence – unless one accepts some *a priori* reason for distinguishing between these groups – the form of Fazel’s analysis should transpose directly from the ‘ex-psychiatric patient/violence’ problem to the ‘black/violence’ problem⁷⁷; doing so, produces, *inter alia*, the following “statements”:

We calculated the population-attributable risk: the number of violent crimes committed per 1,000 persons in the whole population that would *not* have occurred if the risk factor – being black – had been absent.⁷⁸

Assuming that there is a causal relationship between being black and violent crime, one way of interpreting this attributable risk fraction is that violent crime would have been reduced by *circa* 50% if, hypothetically, all those blacks had been institutionalized indefinitely.⁷⁹

To speak of a *causal* link⁸⁰ between black and committing a violent offence is not only manifestly erroneous (because clearly many other factors such as unemployment,

⁷³ Strictly speaking, the analysis should also include details of those imprisoned in federal prisons, but as the example is for illustrative purposes only, these have been omitted for reasons of simplicity.

⁷⁴ United States Bureau of Justice Statistics Bulletin (2009); Appendix, Table 10.

⁷⁵ United States Census figures [online], available:

http://www.allcountries.org/us/census/15_resident_population_by_race_and_projections.html [accessed: 28 May 2009].

⁷⁶ Strictly speaking, Fazel (2006) examined not prisoners imprisoned for a violent offence, but those who had a conviction for a violent offence.

⁷⁷ A comparable Swedish problem concerns the level of violent crime committed by Swedish born children of immigrant parents; these are three times more likely to be convicted of a violent offence than children of Swedish born parents. See: The Local (2005). ‘Immigrants behind 25% of Swedish Crime’. *The Local: Sweden’s news in English*. 14 December. [online], available:

<http://www.thelocal.se/article.php?ID=2683&date=20051214> [accessed: 8 June 2009].

See also Martens & Holmberg (2005), p.72:

It is two and a half times as likely for persons born abroad to be registered as crime suspects as it is for Swedish born persons with both parents born in Sweden. ... Among those with one Swedish born, and one non-Swedish born parent, the risk is 1.4 times as great. ... It is four times as likely, for example, for foreign-born persons to be suspected of lethal violence and robbery as it is for persons born in Sweden to Swedish born parents.

⁷⁸ Adapted from Fazel (2006), p.1398 with ‘*black*’ substituted for ‘*severe mental illness*’.

⁷⁹ *Ibid.*

⁸⁰ Though Fazel (2006) attempts some qualification (p.1400):

poverty, neighbourhood disadvantage, alcohol and drug abuse, are relevant) but irresponsible in that it fosters further stigmatisation and discrimination against blacks. It is no less irresponsible in a context where the media portrayal of the links between mental disorder and violence are so grossly distorted (*supra*) as to result in a public that predominately perceives mentally disordered as dangerous.⁸¹ In an editorial accompanying the publication of Fazel (2006), Appelbaum (2006) summarised Fazel's conclusions as: "These Swedish data confirm an evolving consensus on the relationship between serious mental illnesses and violence."⁸² But, as is shown by Steadman (1998) (*supra*) – and other studies to be discussed below – the relationship is complex, multifaceted and opaque; the consensus, if indeed it exists, is fragile. It behoves commentators, especially academic commentators, to eschew simplistic analyses and to transcend what Sirotych (2008) (*infra*) calls: "...[the] myopic fixation on the clinical correlates of violence."⁸³

B.3.2.1.5: Buchanan (2008)

Buchanan (2008) is principally concerned with the problem of individual risk assessment but, in discussing epidemiological analyses such as Fazel (2006), he highlights the possibility that substance abuse may function as a 'confounding variable'⁸⁴:

It is also the case that potential confounders, such as substance abuse, can be present to a greater or lesser extent. An association between mental disorder and violence that persists after controlling for drug dependence does not exclude the possibility that a disproportionate number of individuals with mental disorders were using substances at a nondependent level. Violence is associated with substance use at levels that fail to meet diagnostic criteria.⁸⁵ Residual confounding of this kind may explain why Scandinavian studies that show the highest odds ratios for substance abuse also report high odds ratios with respect to mental disorder.⁸⁶

... the method of population-attributable risk assumes causality. However, the relationship between severe mental illness and crime is more complex than simple causality, and nonmodifiable risk factors, such as age, gender, socioeconomic status, and previous criminality are important, as are other potentially treatable factors such as substance abuse, personality disorder, and medication compliance. Comorbid substance abuse, in particular, increases the risk of violent crime in those with severe mental illness. [References omitted]

⁸¹ Elbogen & Johnson (2009), p.157:

... national survey in which 75% of the sample viewed people with mental illness as dangerous and 60% believed people with schizophrenia were likely to commit violent acts. [References omitted].

⁸² *Op. cit.*, p.1319.

⁸³ Sirotych (2008), p.188.

⁸⁴ Confounding occurs when one variable has not been separated from a second variable (and has thus been confounded with it) producing a spurious result; thus - in relation to Fazel (2006) - the possibility of having substance abuse has not been separated from the possibility of having a psychiatric history.

⁸⁵ *I.e.* the subjects may not have been 'diagnosed' as drug users.

⁸⁶ Buchanan (2008), p.187. [References omitted] .

This suggests that if the term ‘cause’ can have any purchase in the present debate it may perhaps be more appropriately applied to substance abuse than to psychiatric history; doing so would help reconcile Fazel (2006) with Steadman (1998).

B.3.2.1.6: Elbogen & Johnson (2009)

Data on mental disorder and violence were collected as part of the *National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)* and was analysed by Elbogen & Johnson (2009) in an attempt to elucidate the relationships that may exist between severe mental illness, substance abuse and violence.

They noted that “*The scientific literature on the association between mental illness and violence is inconclusive ...*”⁸⁷ and found that:

... severe mental illness alone did not predict future violence; it was associated instead with historical (past violence, juvenile detention, physical abuse, parental arrest record), clinical (substance abuse, perceived threats), dispositional (age, sex, income), and contextual (recent divorce, unemployment, victimization) factors.⁸⁸

... the incidence of violent behavior, though slightly higher among people with severe mental illness, was only significantly so for those with comorbid substance abuse.⁸⁹

Elbogen & Johnson (2009) concluded that:

The data shows it is simplistic as well as inaccurate to say the cause of violence among mentally ill individuals is the mental illness itself; instead, the current study finds that mental illness is clearly relevant to violence risk but that its causal roles are complex, indirect, and embedded in a web of other (and arguably more) important individual and situational cofactors to consider.⁹⁰

B.3.2.2: Some reviews of the literature

Mullen’s (2001) review of the literature is discussed in B.3.2.2.1; Thornicroft’s (2006), in B.3.2.2.2 and Sirotych’s (2008), in B.3.2.2.3.

B.3.2.2.1: Mullen (2001).

Mullen⁹¹ considers *The MacArthur Violence Risk Assessment Study*⁹² to be “... *the most sophisticated examination to date of the relationship between having a mental disorder and violent and criminal behaviour.*”⁹³

⁸⁷ *Op. cit.*, p.153; they then examine some reasons why this is so.

⁸⁸ *Ibid.*, p.152.

⁸⁹ *Ibid.*, p.155.

⁹⁰ *Ibid.*, p.159.

⁹¹ Mullen (who is Professor of Forensic Psychiatry, Monash University) was commissioned by the Criminology Research Council of Australia to report on the relationship between mental disorder and violence and criminal behaviour.

⁹² The findings were published as Monahan (2001).

⁹³ Mullen (2001), p.7.

The MacArthur study used a sample of over 1,000 subjects admitted to public psychiatric inpatient facilities in Pittsburgh who were extensively evaluated during the year following discharge.

Depending on the definition of 'acts of violence', between 27.5% and 56% of subjects displayed violence.⁹⁴ The prevalence of violence was less amongst those with a major mental disorder⁹⁵ than amongst those with a personality disorder but was highest when linked to substance abuse:

... patients with major mental disorders, including schizophrenia, but without substance abuse, were no more likely to be violent than "*others in their neighbourhood without symptoms of substance abuse.*" Substance abuse was however significantly more common among patients (31% vs. 17%) and amongst patients with substance abuse the prevalence of violence was significantly higher than others in their neighborhood.⁹⁶

Mullen cautions against drawing the overly simplistic conclusion from such studies that substance abuse *causes* offending behaviour in the mentally disordered⁹⁷ and urges the need for further investigation. Having reviewed a number of similar studies, he concludes:

The best established mental health variable in predicting future offending behaviour is the presence of substance abuse. Schizophrenia perhaps should be added to substance abuse but the current confusion created by some interpretations of the MacArthur studies ... have thrown doubt once more over how robust and how relevant is this association.⁹⁸

What is clear is that in long term prediction of violence risk mental health variables, with the possible exception of substance abuse, pale into insignificance

Elbogen & Johnson (2009) (*supra*) noted (p.155) that their results "... yielded results similar to those from the MacArthur Violence Risk Assessment Study."

⁹⁴ Mullen (2001), p.7:

Overt acts of violence were ascertained to have occurred in 27.5% of subjects ... The nature of the identified acts of violence covered the spectrum from hitting to attacks with weapons (3 subjects committed homicide) but excluded what were termed "*other aggressive acts*" which were primarily throwing things, pushing, shoving and slapping. Addition of these lesser forms of violence raised the percentage of perpetrators to 56%.

⁹⁵ These included depression as well as schizophrenia and other psychotic disorders. [Mullen (2001), p.7.]

⁹⁶ Maden (2003b) drew similar conclusions:

The central message of this study is that, for much of the time, patients behave like their friends and neighbours, so far as hitting other people is concerned. ... Once substance misuse was excluded, patients did not have increased rates of violence and their violence followed the normal rules.

The best single predictor of violence was personality disorder ... Violence was also linked to alcohol, to previous violence and to neighbourhood context. (p.237)

⁹⁷ Mullen (2001), p.17:

To a greater or lesser extent substance abuse may reflect, rather than cause, such factors as *anomie*, impulsivity ... Thus in part it may be that those who tend to offend are also those who tend to abuse drugs and alcohol when available, rather than it always being drug and alcohol abuse which ushers in offending behaviours.

⁹⁸ *Ibid.*, p.23.

when they are placed alongside traditional criminological variables like gender, age, past history of offending, and social class.⁹⁹

Mullen's conclusions are supported by both Thornicroft (2006) and Sirotych (2008) which are discussed in the following subsections.

B.3.2.2.2: Thornicroft (2006)

Thornicroft (2006) having noted the prominence given to schizophrenia in the literature on dangerousness,¹⁰⁰ summarises some of the research results:

One study reviewed rates of violent behaviour committed by people with a diagnosis of schizophrenia in seven countries, and found that for men rates were between 3.9–8.0 times higher than for the general population, ...¹⁰¹

Higher levels of substance abuse was found amongst those diagnosed with schizophrenia than amongst the general population¹⁰² which again raises the possibility that the raised level of dangerousness might be more accurately attributed to substance abuse than to schizophrenia – a conclusion suggested by, for example, Steadman (1998) (*supra*).

A further complicating factor is the apparent failure¹⁰³ to incorporate rates of misdiagnosis (or even to advert to its possibility) into the analysis linking dangerousness to schizophrenia. Hickling (1999),¹⁰⁴ for example, found a misdiagnosis rate of 45% in relation to schizophrenia and raised the possibility that this might be due to an (unconscious) racial prejudice amongst white psychiatrists; if this is indeed the case then it is surely possible that a similar prejudice may also enter into the assessment of 'dangerousness' particularly if performed, informally, by psychiatrists.¹⁰⁵ The possibility that some research results were based on data exhibiting such a double prejudice would render the hypothesis that schizophrenia was linked with dangerousness, self fulfilling and the research, valueless.

⁹⁹ *Ibid.*

¹⁰⁰ *Op. cit.*, p.128:

Schizophrenia is a relatively uncommon condition ... nevertheless, such is the fascination of this condition that far more has been written about schizophrenia and stigma than about all other types of mental illness put together, and this is also true in relation to the literature on violence.

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*

¹⁰³ Though see Fazel (2006), p.1398 (*supra*) where a subsequent file-based review did take place which upheld the diagnosis of schizophrenia in 86% of cases.

¹⁰⁴ See Chapter 4.

¹⁰⁵ See, for example, Loring & Powell (1988) who provided identical case histories (changing only the race and sex of the subject) to a group of 290 psychiatrists; the study concluded that (p.18):

Although violent behavior is not imputed to white males or to the females, black males are most likely to be diagnosed as having a paranoid schizophrenic disorder. ... Clinicians appear to ascribe violence, suspiciousness, and dangerousness to black clients even though the case studies are the same as the case studies for the white clients.

In relation to the risk posed by schizophrenia, Thornicroft (2006) concludes that:

The available information suggest that men with a diagnosis of schizophrenia are 3–7 times more likely to commit violent acts than men without this condition, ...¹⁰⁶

He also notes that though depression presents a lower relative risk of violence than schizophrenia, it is responsible for “... *a relatively large actual contribution to violent events because depression is much more common than schizophrenia.*”¹⁰⁷

Thornicroft (2006) then directly addresses the risk posed by substance abuse:

Compared with members of the general population with a similar social background, men with ‘substance use disorder’ were 9–15 times more likely to behave violently, and this risk was 15–55 times higher among women. ... [a] large-scale surveys in the USA ... found that people with alcohol or drug misuse were more than twice as likely as those with a diagnosis of schizophrenia to report being violent.¹⁰⁸

Despite some contrary results, taken together these findings point to the same conclusion: drug or alcohol misuse are strong predictors of violence, are more closely associated with violence than are psychotic disorders, and play a part in contributing to at least one quarter of all violent incidents.¹⁰⁹

B.3.2.2.3: Sirotich (2008).

Sirotich (2008) is a comprehensive review of articles and texts published since 1990 that dealt with crime or violence committed by persons with mental disorder. The review is structured according to the nature of the variables studied: demographic [B.3.2.2.3.1]; historical [B.3.2.2.3.2]; clinical [B.3.2.2.3.3]; and contextual [B.3.2.2.3.4]. Sirotich’s (2008) conclusions are summarised in B.3.2.2.3.5.

B.3.2.2.3.1: Demographic variables

These comprise, for example, biological sex, age, race and socioeconomic status.

Sirotich (2008) found that foremost among these variables was biological sex: “*In the general population, males are much more likely than females to engage in violent and criminal behavior.*”¹¹⁰

He also noted the relationship between race and violence and suggested that further research was required to determine whether this might be “*contextually driven and possibly a product of socioeconomic factors.*”¹¹¹

¹⁰⁶ *Op. cit.*, p.129.

¹⁰⁷ *Ibid.*, p.131.

¹⁰⁸ *Ibid.*, p.132.

¹⁰⁹ *Ibid.*, p.133.

¹¹⁰ *Op. cit.*, p.172.

¹¹¹ *Ibid.*, p.174.

B.3.2.2.3.2: *Historical variables*

These comprise, for example, a previous history of violence or criminality and parental factors and family history.

Sirotich (2008) found that: “*Prior violence and criminality have been found to be the best predictors of future violence and criminality within the criminological literature.*”¹¹²

B.3.2.2.3.3: *Clinical variables*

These comprise, for example, psychiatric diagnosis and substance abuse.

Sirotich (2008) found that:

The importance of psychopathology in explaining criminal and violent behavior among persons with mental disorder is an issue of considerable empirical complexity. A substantial amount of research has explored this issue. ... Yet, the empirical literature yields equivocal findings.¹¹³

Having noted the research which found evidence of such links, he stated: “*There is also a considerable amount of evidence to discount suggestion of any relationship between mental disorder and crime or violence.*”¹¹⁴

He noted that research which sought to establish links between particular diagnostic categories and a propensity to violence, also yielded “*mixed results*”.¹¹⁵

Sirotich (2008) emphasised the importance of substance abuse as a contributor to violence both amongst the mentally disordered (as well as non-disordered persons): “*Across sample groups, substance abuse or dependence was the most consistent predictor of violence or criminality among persons with mental disorder.*”¹¹⁶

He suggested that particular personality traits – such as readiness to anger – rather than specific psychiatric disorders *per se*, might offer a more promising path for future research.¹¹⁷

B.3.2.2.3.4: *Contextual variables*

These comprise, for example, environmental issues such as housing and financial problems; neighbourhood poverty; intoxication; family relationships.

¹¹² *Ibid.*

¹¹³ *Ibid.*, p.176.

¹¹⁴ *Ibid.*, p.177.

¹¹⁵ *Ibid.*; he also lists some of the factors that might explain the existence of such seemingly incompatible results *e.g.*: methodological differences, selection bias and inappropriate diagnostic methods.

¹¹⁶ *Ibid.*, p.180.

¹¹⁷ *Ibid.*, p.181:

That is, it may prove more fruitful to study active symptoms of MMDs as well as dimensional psychological traits rather than categorical disorders such as schizophrenia or ASPD. ... Similarly, specific personality traits such as uncontrolled anger may be more relevant in the study of aberrant behavior than actual personality disorders.

[GR: MMD - Major Mental Disorders; ASPD – Anti Social Personality Disorder]

Sirotych (2008) gave some examples of such studies:

This risk [of violence] doubled when subjects on payeeships or trusteeships had frequent contact with family members. A lack of autonomy associated with not controlling one's own money may ... ultimately precipitate violence toward those controlling one's income and resources.¹¹⁸

... found that concentrated neighborhood poverty increased risk of violence among patients discharged from hospital by nearly threefold.¹¹⁹

B.3.2.2.3.5: Sirotych's (2008) conclusion

Sirotych's (2008) final conclusion relates to the excessive concentration on clinical variables in research studies:

Failing to control for contextual correlates of violence and criminality increases the risk of overstating the effect of clinical variables. Indeed, part of the reason for the lack of consistency among prior studies may be related to a myopic fixation on the clinical correlates of violence and crime and a concomitant inattention to how clinical and environmental factors may interact to increase or attenuate the risk of violence and criminality by person with mental disorder.¹²⁰

Whereas the prevalence of violence clearly presents a serious problem for society, it should not be overlooked that psychiatrists have a professional interest in viewing it through the narrow lens of psychiatric diagnosis¹²¹ and that the myopia to which Sirotych (2008) refers, is not necessarily the product of disinterested forces.

B.4: Section B conclusions

The above discussion enables the following conclusion to be drawn:

Although there is a widespread belief amongst the general public, that the presence of mental disorder greatly heightens the risk of violence, the preponderance of research indicates that – in the absence of substance abuse – the risk of violence is no greater than that occurring in the general population and, furthermore, that substance abuse itself is the best predictor of violent behaviour.

Section C: The prediction of individual dangerousness (*i.e.* risk assessment)

The discussion in Section B related to whether, considered in its full generality, the diagnosis of mental illness (or the diagnosis of a specific mental illness) could, of itself,

¹¹⁸ *Ibid.*, p.185.

¹¹⁹ *Ibid.*

¹²⁰ *Ibid.*, p.188. [References omitted]

See also Buchanan (2008), p.187: “*The predictive accuracy of even the simplest behavioral measures seems to exceed the predictive power of diagnosis.*”

¹²¹ See Carmel (1999) where Englander (the author of a textbook [Englander (1997)] entitled *Understanding Violence*) is taken to task for criticising the “*mental illness model of violence*” as being less tenable than other theories. See also Englander (1999).

be regarded as a reliable indicator of a propensity to commit acts of violence; it concluded that it could not. The problem to be discussed in the present section concerns the task of assessing¹²² whether a particular subject will behave violently at some future time in circumstances where the subject presents no imminent danger to others.

It is not obvious that psychiatry, as a discipline, has any especial expertise in assessing a subject's 'dangerousness to others,'¹²³ indeed there is authoritative judicial authority to the contrary: in *Cross v Harris* (1969) the US Court of Appeals – having noted that “a finding of ‘dangerousness’ must be based on a high probability of substantial injury.”¹²⁴ – stated:

Without some such framework, “dangerous” could readily become a term of art describing anyone whom we would, all things considered, prefer not to encounter on the streets.

... Psychiatrists should not be asked to testify, without more, [*sic*] simply whether future behavior or threatened harm is “likely” to occur. For the psychiatrist “*may – in his own mind*” be defining “likely” to mean anything from virtual certainty to slightly above chance. And his definition will not be a reflection of any expertise, but ... of his own personal preference for safety or liberty.¹²⁵

However, by a process of “judicial default,”¹²⁶ the determination of a subject's ‘dangerousness to others’ commonly falls to be effectively determined by psychiatrists and this is the context within which the term will be understood for the remainder of this chapter.

Some techniques have been developed which purport to assist psychiatrists in making individual risk assessments but their reliability has been questioned as has the propriety of their use in circumstances where the possible consequences of an erroneous assessment are grave.

¹²² *I.e.* making a ‘risk assessment’.

¹²³ Foucault is dismissive not only of any such claim to expertise but also of the role played by psychiatry in a modern criminal trial; see, for example:

I simply want to underline this strange fact, that psychiatrists have tried very stubbornly to take their place in the legal machinery. They justified their right to intervene, not by searching out the thousand little visible signs of madness which may accompany the most ordinary crimes, but by insisting – a preposterous stance – that there were kinds of insanity which manifested themselves only in outrageous crimes, and in no other way. ... Crime then became an important issue for psychiatrists, because what was involved was less a field of knowledge to be conquered than a modality of power to be secured and justified. [Foucault (1978), p.6].

¹²⁴ Shah (1977), p. 102.

Shah (1977) (p.104) also quotes, with approval, the definition of ‘dangerous to others’ contained in the Arizona Criminal code:

“*Danger to others*” means behavior which constitutes a danger of inflicting substantial bodily harm upon another person based upon a history of having inflicted or having attempted to inflict substantial bodily harm upon another person within twelve months preceding the hearing on court order treatment.

¹²⁵ *Op. cit.*, pp.1100-1; quoted in Shah (1977), p.104.

¹²⁶ Shah (1977), p.98.

In Subsection C.1, the ethical problems associated with psychiatric risk assessment are examined from a more general perspective: that of state sanctioned ‘selection procedures’ – e.g. the criminal justice system – which have as a consequence that a subject, so selected, suffers some detriment. Two such problems are identified – the ‘false positive’ problem and the ‘comparable risk’ problem – and some relevant ethical principles are identified. The practice of psychiatric risk assessment is reviewed in the light of these principles in Subsection C.2. Some conclusions are drawn in Subsection C.3 concerning the reliability of psychiatric risk assessments.

C.1: Prediction of individual dangerousness: some ethical problems and principles

It is a truism of criminal jurisprudence to say that it is not possible to create a system to determine guilt which is incapable of error. Error is intrinsic to any such procedure and a decision must be made, at a theoretical level, concerning both the level of error that is acceptable and the party in whose favour doubt must be resolved; in common law jurisdictions such decisions are embodied in the maxims that the guilt of an accused in a criminal trial must be ‘*proved beyond a reasonable doubt*’ or, alternatively, ‘*Better that ten guilty persons escape than that one innocent suffer.*’ In the present context, the 10:1 ratio¹²⁷ is the most useful formulation of the principle in relation to criminal law.

Volokh (1997) is an analysis of the origin and development of this principle and it also touches on two points of immediate relevance to this dissertation:

- the ratio that should apply in suing a psychiatrist for malpractice [C.1.1];
- the ratio that should apply to a civil commitment. [C.1.2]

A discussion of these points enables the identification of two ethical principles – ‘*Principle A*’ [C.1.3] and ‘*Principle B*’ [C.1.4] – that should govern the psychiatric committal process .

C.1.1: The ratio deemed legally appropriate to psychiatric malpractice

Volokh (1997) notes that:

A British court, in 1883, held ... that $n = \text{infinity}$ for attorneys sued for slander. If the rule were otherwise, the court explained, “*the most innocent of counsel might be unrighteously harassed with suits.*”

... *Gregoire v Biddle*, a 1949 opinion in which Judge Learned Hand explained that we couldn't subject conscientious bureaucrats “*to the constant dread of retaliation.*”

¹²⁷ The 10:1 ratio is known as the ‘Blackstone ratio’ after the English jurist William Blackstone. [See Volokh (1997)].

The sentiment which sought to give special protection to lawyers and bureaucrats lest they be unduly harassed by the disaffected, appears to find a rebirth in Irish mental health law¹²⁸ which accords to psychiatrists, a level of protection from civil suits for negligence, unknown to other health professionals.

C.1.2: The ratio deemed legally appropriate to civil commitment

The US Supreme Court has not extended the presumption against wrongful conviction to the context of civil commitment; in *Addington v Texas* (1979) the Chief Justice wrote that:

... the interests of people wrongfully committed to a mental institution would be protected by the "*concern of family and friends*."
"Moreover," Chief Justice Burger wrote, "*it is not true that the release of a genuinely mentally ill person is no worse for the individual than the failure to convict the guilty. One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma. ... It cannot be said, therefore, that it is much better for a mentally ill person to 'go free' than for a mentally normal person to be committed.*"¹²⁹

The reasoning of the Chief Justice appears almost perverse in that it assumes:

- *firstly*, that the "*concern of family and friends*" could ensure that a wrongful committal be reversed.

The earlier discussion [e.g. Manweiler, Juklerød and papers such as Rosenhan (1973), Margolin (1995) and Witztum (1995a)] should be sufficient to illustrate the difficulty in challenging a psychiatric diagnosis, once made.

Furthermore, it is not unknown for a subject's family – for their own personal or financial reasons – to have set in motion the process that led to the wrongful committal.

- *secondly*, that the presumption against wrongful conviction is based on the presumed benefit to the guilty, rather than the clear detriment to the innocent; with the implicit – but unjustified – suggestion, on the one hand, that if there are circumstances where there is no benefit in letting the guilty go free, then the principle has no application;¹³⁰ and, on the other hand, that the possibility of a persisting, and unredressed, wrongful committal is so slight as to be negligible.¹³¹

¹²⁸ *Mental Health Act* (2001), s.73(1).

¹²⁹ Volokh (1997).

¹³⁰ It may appear that the principle:

It is much better for a guilty person to go free than for an innocent person to be imprisoned.

is logically equivalent to:

It is much worse for an innocent man to be imprisoned than for a guilty man to go free.

on the basis that the first [*A is better than B*] necessarily implies, and is implied by, the second [*B is worse than A*]. But the formulation used by Chief Justice Burger is something of an oratorical sleight of

The issue before the court in *Addington v Texas* (1979) was whether the standard of proof required for a civil commitment was a ‘beyond reasonable doubt’ standard [as in a criminal trial (1:10)], or a ‘balance of probabilities standard’ [as in a civil action (1:1)] or some intermediate standard.

Whilst acknowledging that:

This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.¹³²

the court held for the intermediate standard and offered as reasons:

- the “*layers of professional review and observation*”¹³³ would help correct any erroneous decision;¹³⁴
- grave doubt that the state could ever meet the ‘reasonable doubt’ standard;¹³⁵
- that unlike a criminal confinement which is purely punitive, a civil commitment involves the *parens patriae*¹³⁶ jurisdiction of the court and the ‘reasonable doubt’ standard would “*erect an unreasonable barrier to needed medical treatment.*”¹³⁷

The court appeared to place emphasis on the fact that one subjected to civil commitment would receive ‘treatment’ and that this would help ameliorate the negative aspects of involuntary detention,¹³⁸ thus reducing the need for adherence to a ‘reasonable doubt’ standard of proof and permitting some lesser standard.

hand to permit the focus of the analysis to rest completely on the presumed benefit to the guilty in granting them their release.

Thus the standpoint adopted by the Chief Justice is that of the guilty man set free (or the insane man not committed) whereas the defence of the Blackstone principle rests on adopting the perspective of the innocent man wrongly convicted (or the sane man wrongly committed) – a perspective which would urge a diametrically opposite conclusion to that drawn by the court.

¹³¹ See Chapter 4 where it is concluded that the rate of committals grounded in a psychiatric misdiagnosis is of the order of 25%.

¹³² *Op. cit.*, p.425.

¹³³ *Op. cit.*, p.428.

¹³⁴ See *supra*.

¹³⁵ *Op. cit.*, p.429:

Given the lack of certainty and the fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous.

¹³⁶ *Op. cit.*, p.426: “*The state has a legitimate interest under its parens patriae powers in providing care to its citizens who are unable, because of emotional disorders, to care for themselves;*”

¹³⁷ *Op. cit.*, p.432.

¹³⁸ A similar line of reasoning is evident in a later case where the US Supreme Court considered the use of preventive detention against convicted sex offenders who had completed their sentence but who were considered to pose a danger to others; the Court stated:

By furnishing such treatment, the Kansas Legislature has indicated that treatment, if possible, is at least an ancillary goal of the Act, which easily satisfies any test for determining that the Act is not punitive.

[*Kansas v Hendricks* (1997), note 5.]

C.1.3: The first ethical principle [*‘Principle A’*]

Saleem Shah, a noted jurist¹³⁹ who wrote extensively on the principles that should inform mental health law, argued:

[for the] ... critical importance of separating – analytically, conceptually, and in actual practice—the *parens patriae* and police power functions involved in commitment of the mentally ill.¹⁴⁰

... very important substantive and related procedural differences between these two commitment criteria tend to be thoroughly confounded in legislation and in judicial opinions. And, when questions are raised about adequate procedural safeguards for persons facing involuntary confinement in order to protect the community (*i.e.*, police power commitments), it has been easy to fudge and to avoid the critical issue by referring to the benevolent *parens patriae* purposes also stated in the statute.¹⁴¹

He argued that the confounding of these powers has been responsible for the greatest confusion in this area,¹⁴² yet it is just such a confounding that permeates the Supreme Court judgement in *Addington v Texas*.

[*Note:* In setting forth the structure of this dissertation, an analytical structure was adopted which separately analysed coercive interventions undertaken in the interests of the subject (*Stage 1*) from those undertaken in the interests of others (*Stages 2 and 3*). This method was chosen for reasons of logical clarity and (at the time) in ignorance of Shah (1977), but it is precisely the method that he advocated in relation to legal proceedings concerning psychiatric committal.]

Restricting the discussion to interventions undertaken for the sake of others (the focus of the current chapter) and ignoring the possibility of benefit¹⁴³ from ‘treatment’, it is difficult to gainsay Shah’s point that the deprivation of liberty of the wrongly convicted subject is on all fours with the deprivation of liberty of the wrongly committed – *i.e.* that the consequence of error for the individual wrongly deprived of liberty is identical whether he be wrongly imprisoned or wrongly committed.

Indeed it is possible to argue that the fate of one wrongly committed is considerably worse than one wrongly convicted in that his protestations are likely to be regarded as further proof of the correctness of his committal¹⁴⁴ and as warranting, if anything, further coercive treatment.

¹³⁹ The February 1995 issue of *Law and Human Behavior* contained a series of articles written in memory of Shah and honouring his “contributions to the development of concepts and research in law and mental health.”

¹⁴⁰ Shah (1977), p.93.

¹⁴¹ *Ibid.*, p.94.

¹⁴² *Ibid.*, p.93.

¹⁴³ For those who are wrongly committed, the coercive administration of psychoactive drugs such as antipsychotics, is clearly a detriment [*vide supra* Manweiler’s description of being like a “zombie”] and could under no circumstances be considered to be a ‘benefit’.

¹⁴⁴ See the discussion on ‘denial’ in Chapter 4.

The minimal conclusion that should be drawn is that the margin of error should be the same in both cases *i.e.* that the standard of proof required for a committal on the grounds of dangerousness to others should be the same as for a criminal conviction that is of the order of 10:1.

This conclusion implies the following principle:

Principle A: A psychiatric risk assessment deemed sufficient to warrant an involuntary committal on the grounds of dangerousness to others should have an error rate of no greater than 1 in 10.

C.1.4: The second ethical principle [‘Principle B’]

Shah’s (1977) analysis is also of assistance in formulating the second ethical principle which is that individuals who pose an equal danger to others must – in relation to their dangerousness – be treated equally; he states:

The definition and handling of “*dangerous*” behavior are very much influenced by the power structures that exist in a society. ... Many other individuals and groups that clearly pose greater and more readily demonstrated dangers to society (*e.g.*, drunken drivers and persons convicted of felonious crimes against [the] person) do *not* seem to evoke similar concerns about the use of preventive detention to protect the community from danger.¹⁴⁵

It is interesting, even astonishing, that the police power authority to protect the community can be so readily invoked for the commitment of the mentally ill, yet similar statutory provisions are typically lacking to safeguard the citizens from known “*potential menaces to society.*” One might expect that since the mentally ill have been elected for such preventive confinement there must certainly be some very clear and convincing evidence showing that they constitute one of the most dangerous groups in our society. However, such evidence does not exist.¹⁴⁶

Shah argues that it “*would not be politically acceptable*”¹⁴⁷ to detain members of such other subgroups and asks:

Thus, even though the validity of the state’s interest in protecting society cannot be disputed, serious moral (and perhaps equal protection) problems arise if one asks why the mentally ill have been singled out for such preventive confinement in the absence of any clear and convincing evidence that they truly constitute one of the most dangerous groups in our society? ... – the treatment objectives seem to be dragged in presumably to remedy and possibly even to avoid addressing the other substantive issue.¹⁴⁸

¹⁴⁵ Shah (1977), p.106.

¹⁴⁶ *Ibid.*, p.111. [References omitted].

¹⁴⁷ *Ibid.*, p.118; Irish mental health law prohibits involuntary committal on the grounds of alcoholism. [See *supra*]

¹⁴⁸ *Ibid.*, p.115; see also p. 113:

One is led to conclude that rejecting attitudes toward the mentally ill and the perceptions of their unpredictability and threat—and not their actual and demonstrated “*dangerousness*” seem to provide the major basis for public policies ... [Emphasis in original].

This avoidance of scrutiny is “... customarily missing when laws affect only the voiceless in society.”¹⁴⁹ – an observation which leads him to the conclusion that:

... quite obviously the mentally ill are not afforded equal protection of the laws since civil commitment procedures typically do not provide the full panoply of procedural due process protections.¹⁵⁰

Szmukler,¹⁵¹ who provides an analysis of these issues closely resembling that of Shah, has written extensively on psychiatric risk assessment and has been highly critical¹⁵² of those who, in adopting a cavalier attitude to the mathematical intricacies of risk analysis,¹⁵³ are dismissive of ‘false positives’ and the “*potentially serious consequences of being wrongly classed as dangerous.*”; – this latter he identifies as the ‘values’ problem, in contrast to the ‘fact’ problem which is concerned with the use of appropriate mathematical techniques.¹⁵⁴

In discussing the ‘values’ problem, Szmukler (2003) reaches conclusions similar to those of Shah (1977) (*supra*):

Given society's long history of prejudice against mentally ill individuals, the threat to this socially-excluded group is very worrying. Even more fundamental is an issue that reveals a discrimination against people with mental disorder that is rarely challenged. The ethical principle in question is that of ‘*fairness*’ or ‘*justice*’. The principle of justice, defined by Aristotle more than 2000 years ago, is that ‘*equals should be treated equally and unequals unequally*’. ... Can we justify the preventive detention of people with mental disorders on the grounds of their risk to others, but not the remainder of persons, equally dangerous, ...? The answer is no.¹⁵⁵

Unless all of us are equally liable to preventive detention for posing the same level of risk to others, irrespective of whether we are mentally disordered or not, we discriminate against those who have the designation of mental disorder.¹⁵⁶

Szmukler (2003) then tackles the justification often offered for the disparity: that the detention of the mentally ill is acceptable because they receive ‘treatment’. He argues that such purported justifications – in confounding the health interest of the patient and the protection of the public¹⁵⁷ – serve as a convenient veil¹⁵⁸:

¹⁴⁹ *Ibid.*, p.118.

¹⁵⁰ *Ibid.*, p.116. [Emphasis in original].

¹⁵¹ George Szmukler is a consultant psychiatrist and Dean of the Institute of Psychiatry at King’s College, London.

¹⁵² See *infra* and Appendix F.

¹⁵³ Szmukler (2001a), p.82: “*It is difficult to describe how prediction instruments perform in a way that is easily comprehensible to non-mathematicians.*”

¹⁵⁴ See Szmukler (2003), p.206.

¹⁵⁵ *Ibid.*

¹⁵⁶ *Ibid.*

¹⁵⁷ Compare Shah’s (1977) analysis (*supra*) of the confounding by the US courts, of the ‘police power’ and ‘*parens patriae*’.

Some will argue that the ‘treatability’ of those with mental disorders is a justification. This cannot be the case. Our secure hospitals are filled with large numbers of apparently dangerous mentally ill people who have proved resistant to treatment. Nor is there any reason not to believe that nonmentally disordered, dangerous persons may be just as likely, if not more likely, to respond to ‘psychosocial treatment’ programmes to reduce their risk of violence (*e.g.* structured groups for those who habitually drink and drive, interventions based on exposure to victims, *etc.*)¹⁵⁹

The above discussion gives rise to the second ethical principle:

Principle B: Individuals who pose an equal danger to others must – in relation to their dangerousness – be treated equally.

This ethical principle has a corollary: that the involuntary detention by the State of members of one social subgroup on the grounds of their dangerousness to others whilst members of a different subgroup who pose an equal or higher level of dangerousness to others, suffer no similar deprivation of liberty, implies that the personhood (in the sense of the ‘cluster of rights’) of members of the first subgroup is diminished.

C.2: The principles as reflected in psychiatric practice

In the context of *Principle A*, the level of ‘false positives’ occurring in psychiatric risk assessments is discussed in C.2.1.

In the context of *Principle B*, the level of dangerousness to others posed by subgroups other than those with a psychiatric history, is discussed in C.2.2.

C.2.1: Principle A and the ‘false positive’ problem

The problem of psychiatric risk assessment (and the associated problem of ‘false positives’) is complicated by the fact that it involves an understanding of so-called ‘base rate errors’ which in turn depend on a somewhat technical branch of probability theory known as ‘*Bayesian analysis*’.¹⁶⁰

Goldacre (2009)¹⁶¹ gives a very clear exposition of the underlying issues as they relate to the identification of terrorist suspects:

Let's imagine you have an amazingly accurate test, and each time you use it on a true suspect, it will correctly identify them as such eight times out of 10 (but miss them two times out of 10); and each time you use it on an innocent person, it will

¹⁵⁸ Initial drafts of the UK *Mental Health Bill* contained provisions which would have permitted involuntary committal even in circumstances “*where there would have been no defined therapeutic benefit.*” - a provision which, if enacted, would have removed the last vestiges of the veil. [See *supra* and Bamrah (2007), p.1029].

¹⁵⁹ Szmukler (2003), p.206.

¹⁶⁰ The importance of Bayesian analysis to the making of probability assessments such as those used by psychiatrists, is discussed in Appendix F and – in relation to the supposed link between jealousy and dangerousness – in Section A (*supra*).

¹⁶¹ Goldacre, B. (2009). ‘Spying on 60 million people doesn't add up.’ *The Guardian*. 28 February. Ben Goldacre is a psychiatrist.

correctly identify them as innocent nine times out of 10, but incorrectly identify them as a suspect one time out of 10.

These numbers tell you about the chances of a test result being accurate, given the status of the individual, which you already know ... But you stand at the other end of the telescope: you have the result of a test, and you want to use that to work out the status of the individual. That depends entirely on how many suspects there are in the population being tested.¹⁶²

The necessity to incorporate knowledge of the number of suspects in the population being tested – when, in Goldacre’s telling phrase, “*stand[ing] at the other end of the telescope*” – is known as the ‘baseline problem’:

... even with the most brilliantly accurate test imaginable, your risk of false positives increases to unworkably high levels, as the outcome you are trying to predict becomes rarer in the population you are examining.¹⁶³

Goldacre’s article was a response to proposals to implement a mass screening for possible terrorists, he concluded:

We are invited to accept that everybody's data will be surveyed and processed, because MI5 have clever algorithms to identify people who were never previously suspected. There are 60 million people in the UK, with, let's say, 10,000 true suspects. Using your unrealistically accurate imaginary screening test, you get 6 million false positives. At the same time, of your 10,000 true suspects, you miss 2,000.¹⁶⁴

The ignoring of the base rate is common¹⁶⁵ in studies relating to psychiatric risk assessment as, for example, the suggested links between delusions of jealousy and violence (see Section A *supra*). It has even been used surreptitiously by those who are fully aware of its importance: in the OJ Simpson trial, Simpson’s attorney (Harvard law professor Alan Dershowitz) exploited the court’s misunderstanding of Bayes' Theorem to argue against a point made by the prosecution who had argued that the fact that Simpson had abused his wife, made it likely that he was responsible for her murder. Dershowitz argued that since 4 million women are abused each year but only 1,400 killed by their abusers, the odds of Simpson being responsible were only 1 in 2,500. This analysis, however, gives the odds of an abused woman being killed; the question that should have been posed was: ‘*If a battered woman is murdered, what are the odds*

¹⁶² *Ibid.*

¹⁶³ *Ibid.*

¹⁶⁴ *Ibid.*, and continued:

If you raise the bar on any test, to increase what statisticians call the “*specificity*”, and thus make it less prone to false positives, then you also make it much less sensitive, so you start missing even more of your true suspects. Or do you just want an even more stupidly accurate imaginary test, without sacrificing true positives? It won't get you far. Let's say you incorrectly identify an innocent person as a suspect one time in 100: you get 600,000 false positives.

¹⁶⁵ See Appendix F.

that her abuser killed her?' and the answer is 90% – a statistic which went unmentioned in the trial.¹⁶⁶

A particularly egregious example of the error occurred in Dolan & Doyle (2000) which had as its aims “*To review the current status of violence risk prediction research*”; in analysing this article, Szmukler (2001a) commented:

... [Dolan & Doyle (2000)] present only one half of the story. How well do the best instruments perform in the real clinical world where prediction leads to action, including restrictions on the liberty of patients regarded as dangerous? False positives are very serious from an ethical (including resource allocation) point of view. Here we encounter the ‘base rate’ problem that the authors inexplicably fail to mention.¹⁶⁷

The various types of psychiatric risk assessment are discussed in C.2.1.1. The error rates associated with these tests are discussed in C.2.1.2 and, in particular, those associate with clinical (*i.e.* intuitive) risk assessment, in C.2.1.2.1; and with actuarial (*i.e.* mathematical) risk assessment in C.2.1.2.2.

The attitude of psychiatrists (as manifested in clinical practice) towards errors in psychiatric risk assessments, is discussed in C.2.1.3.

C.2.1.1: Types of psychiatric risk assessment

Psychiatric risk assessment is either ‘*clinical*’ (an informal assessment based on clinical judgement) or ‘*actuarial*’ (based on mathematical techniques); the latter is also known as ‘*standardised risk assessment*’.

Maden (2003a), in an editorial, suggests that British psychiatrists are reluctant to use standardised risk assessment techniques and prefer to rely on clinical judgement; he offers a number of reasons as to why this might be so; the first being “*fear of unemployment*”,¹⁶⁸ the second concerns the danger of stigmatisation resulting from “*the*

¹⁶⁶ Mlodinow (2009), p.120.

Swanson (2008) makes a similar, but apparently unconscious, error in discussing the report on the Virginia Tech shootings:

The report asserted that “*there are particular behaviors and indicators of dangerous mental instability that threat assessment professionals have documented among murderers*” and that in Cho’s case the professionals either did not see these warning signs or ignored them. (p.191).

A knowledge of particular ‘signs’ amongst those who have committed murder does not allow you to predict that a particular subject (who possesses these ‘signs’) may commit murder unless you know the prevalence of these ‘signs’ in the general population.

¹⁶⁷ Szmukler (2001a), p.84; his criticism is discussed in more detail in Appendix F.

¹⁶⁸ Maden (2003a), p.202: “*The Luddite position, though rarely made explicit, is that clinical skills will become obsolete if use of these scales allowed to spread.*”

Swanson (2008) also suggests that the financial interests of psychiatrists are the reason why actuarial tests are not used in the US:

*mystique attached to some of these tests.*¹⁶⁹ – a mystique which, according to Mullen (2001), is based not on an understanding of science but on scientism – *i.e.* the attempt, by using spurious numerical methods, to create the illusion of precision and thus enable supposition to masquerade as science.¹⁷⁰

In a further editorial, Maden (2005) urges¹⁷¹ his colleagues to accept standardised risk assessment techniques because the pressure from politicians has been such that any hesitation on their part will ensure that the task is undertaken by others.¹⁷²

C.2.1.2: Error rates associated with psychiatric risk assessment

C.2.1.2.1: The reliability of clinical risk assessment

Perhaps the clearest indicator of the error rate of clinical psychiatric assessments occurred in the US as a consequence of court case¹⁷³ which resulted in the release from maximum security hospitals, of 966 patients who had been detained on the grounds of their dangerousness; a four year follow up found that “*only 20% had been reconvicted, the majority for non-violent offences.*”¹⁷⁴

Dolan & Doyle (2000) offers some hope that clinical reliability has improved in the interim:

Clinicians may be better than was believed in the immediate aftermath of Baxstrom studies (Cocozza & Steadman, 1976). Gardner *et al* (1996), for example, showed that while actuarial measures were better than clinical ratings, clinical ratings were better than chance.¹⁷⁵

Then there is the business–model problem. Structured risk assessment is not reimbursed by insurance the way medical tests are, where doctors can make almost as much money doing screening procedures as they could be sued for if they did not. (p.192).

¹⁶⁹ *Ibid.*

¹⁷⁰ Mullen (2001), p.22:

The problem is however the expectations generated and encouraged by advocates of these approaches ... lead clinicians to offer spurious certainties based on a science which in application degenerates to a scientism (Mullen in press). Norko (2000) described the dilemma writing “*such techniques are traps (and are) unlikely to ever assist clinicians in the real time decisions they are called upon to make on a daily basis*” (p. 280).

Similar attempts by the banking industry to acquire the “*shiny veneer of scientific exactness*” have been described by Casey (2009):

Risk has had a firm hold at the top of the corporate agenda. Using a toolkit called enterprise risk management (ERM), chief risk officers quantified all potential risks facing a business.

Quantitative models with the shiny veneer of scientific exactness were used to determine the variance–at–risk (VAR) for each risk category.

Casey, D. (2009). ‘New culture of openness needed to get us on track’. *The Irish Times*. 22 December.

¹⁷¹ Maden (2005), p.121: “*Those clinicians opposed to standardisation cling to the fantasy that violence risk assessments are an optional extra for psychiatrists.*”

¹⁷² The National Health Service managers had introduced a form of standardised risk assessment: “*The impetus behind the forms was that they were, literally, better than nothing. The problem is that they are not much better.*” [Op. cit., p.122.]

¹⁷³ *Baxstrom v Herald* (1966).

¹⁷⁴ Dolan & Doyle (2000), p.303.

¹⁷⁵ *Ibid.*, p.304.

Swanson (2008) is less sanguine: “Using clinical judgment alone, mental health professionals cannot predict individual patient violence much more accurately than chance.”¹⁷⁶

As might be expected, clinical psychiatrists have more confidence in the rightness of their own judgement but such confidence in unaided clinical judgement may be seriously misplaced.¹⁷⁷

An analogy can be drawn between the unsupported belief¹⁷⁸ by a clinical psychiatrist that a subject will at some future time, present a danger to others (and on that ground, should be detained), and police ‘knowledge’¹⁷⁹ that an accused is guilty of a crime (and that on that basis should be imprisoned). In that such police ‘knowledge’ is regarded as clearly providing inadequate grounds for imprisonment, an application of *Principle A* would imply that a bare clinical assessment that a subject posed a future danger to others, should also be inadequate.

C.2.1.2.2: The reliability of actuarial risk assessment

Mullen (1984) – who speaks of “*psychiatric conceits in this area*”¹⁸⁰ – in a telling description of the underlying difficulties, spoke of how it would be necessary to confine 150,000 “innocent Kiwis” each year to prevent the commission of 570 assaults.¹⁸¹

The discussion on reliability sometimes distinguishes between assessing the risk of homicide [C.2.1.2.2.1] and assessing the risk of serious assault [C.2.1.2.2.2] but this distinction is somewhat artificial in that whether an assault ends in death may depend purely on chance.¹⁸²

That the tossing of a coin might be used as a benchmark on which to gauge success should, of itself, be regarded as a damning indictment.

¹⁷⁶ Swanson (2008), p.191.

¹⁷⁷ See Appendix F.

¹⁷⁸ *I.e.* in the absence of factual evidence – such as a previous history of violence – that could convince an independent tribunal.

¹⁷⁹ With insufficient evidence to convince an independent tribunal.

¹⁸⁰ *Op. cit.*, p.9.

¹⁸¹ A direct quotation from Mullen (1984) is given in the Introduction.

¹⁸² Prins (2000), p.152:

... whether an assault ends in the death of a victim may depend upon a degree of serendipity, for example, the thickness of a victim's skull, their general health or the availability of emergency services.

C.2.1.2.2.1: Risk of homicide

Szmukler (2000) notes that the absolute risk of being killed by a stranger with psychosis “... is around the same as that of being killed by lightning – about 1 in 10 million.”¹⁸³ and that:

Risk factors for violence by mentally ill persons are common, but homicide is extremely rare. If all persons with risk factors were treated as potential perpetrators of homicides we would deprive many thousands of their liberty to (possibly) avoid one death.¹⁸⁴

Crawford (2000) makes a similar point: “...for everyone identified correctly, 5000 people will be identified as being at high risk of committing a homicide but will not do so.”

Kennedy (2001) argues that the debate should move from predicting homicide to predicting violence.¹⁸⁵

C.2.1.2.2.2: Risk of serious violence

Kennedy (2001) notes that: “... at 90% sensitivity and 90% specificity ... there would be 4.95 false predictions of reported crimes of violence per accurate prediction.”¹⁸⁶

Szmukler (2001b), however, considers Kennedy’s test presumptions to be “wildly unrealistic. In the real world, a test with a ‘sensitivity’ of 0.52 and a ‘specificity’ of 0.68 is closer to the mark.”¹⁸⁷ and that using such figures:

... the ‘positive predictive value’ (the proportion of positive predictions that turn out correct) for base rates of violence in the patient population of 1%, 5%, ... are 0.02, 0.08, ... respectively. ... This means that if violence occurs in say 5% of a patient population, the predictive test will be wrong 92 times out of 100. In an inner-city community mental health team setting we found around that frequency of patients committed an act of violence against persons in a 6 month period ...¹⁸⁸

Buchanan (2008) in a review of contemporaneous research on psychiatric risk assessment, focused on the levels of accuracy that can be achieved and the prospects for improvement. He suggests that, in assessing various tests, the question to be posed should be:

... if a particular instrument was used as a screening test and those identified as likely to be violent were not discharged, over any given period how many patients would need to be detained to prevent one unwanted act?¹⁸⁹

¹⁸³ *Op. cit.*, p.6.

¹⁸⁴ *Ibid.*, p.7.

¹⁸⁵ Kennedy (2001), p.208: “Violence, because it is more common, should be easier to predict than homicide.”

¹⁸⁶ *Ibid.*

¹⁸⁷ *Op. cit.*, p.359.

¹⁸⁸ *Ibid.* [Emphasis added].

¹⁸⁹ *Op. cit.*, p.185.

In an indication of how well one of the most common tests [the ‘Violence Risk Assessment Guide’ (VRAG)] performs, he states:

Used as a screening test where the base rate of violence is 10% and where, as a result, an unselective approach would lead to the detention of ten people in order to prevent one from acting violently, the VRAG would require the detention of five people to achieve the same end.¹⁹⁰

Because the number needed to be detained, rises as the measure of prevalence falls, if the requirement of ‘*acting violently*’ is restricted to ‘*serious acts of violence*’ or ‘*violence causing injury*’ the number needed to detain rises to 15.¹⁹¹ These figures are unlikely to improve even with the advent of more sensitive tests:

At the prevalence rates seen in most psychiatric outpatient settings, even a substantial improvement in an instrument's psychometric qualities may have limited effect. At the 3.6% base rate in the CATIE study, for instance, a 20% increase in sensitivity, all other things being equal, reduces the number needed to detain only to 13.¹⁹²

Furthermore although clinicians believe that substantially greater accuracy is possible for short-term predictions or for particular symptom clusters or for particular offences this has yet to be tested and confirmed.¹⁹³

The following conclusion may be drawn:

The error rate encountered in the psychiatric assessment of dangerousness lies between 80% and 93% depending on the criterion used to define ‘violence’, thus violating Principle A which specifies an error rate no greater than 10%.

C.2.1.3: Psychiatric attitudes to errors in psychiatric risk assessment

As discussed in Appendix F, Maden (2001) was dismissive of Szmukler's (2001) negative response to Dolan & Doyle (2000) and stated:

In any case, the low baseline is irrelevant. Most risk assessment tools were developed on high-risk populations, usually people who had already committed serious offences. They were not designed to be applied to all patients.¹⁹⁴

Since 2000, however, the UK government has stipulated that mandatory risk assessment be performed on all ‘service users’.¹⁹⁵

Higgins (2005) was the first study to provide an overview of clinical practice in relation to violence risk assessment in England; it found that most health trusts had a standardised form in place for assessing the risk of violence and less than half had

¹⁹⁰ *Ibid.*

¹⁹¹ *Ibid.*

¹⁹² *Ibid.*

¹⁹³ *Ibid.*, p.184-5.

¹⁹⁴ Maden (2001), p.479; this is a further instance of base rate error.

¹⁹⁵ Higgins (2005), p.131.

provided some (c. half-day) training in their use, though: “*It was of note that where training was in place, many respondents commented that they had not attended it.*”¹⁹⁶

The absence of any adequate training allied with seemingly vague criteria¹⁹⁷ adds additional emphasis to Higgins’ (2005) conclusion:

The rationale behind using scoring or grading systems to summarise risk was not clear. Scores may be reproducible, and thus seem ‘scientific’, but their validity for use with the general population is questionable. There was often a lack of direction as to how a score or grade should be meaningfully interpreted. ... Around half of the forms did not include a plan for managing any identified risk.¹⁹⁸

Against such a background, Maden (2003a) nonetheless poses the rhetorical question “*Why all the fuss?*”¹⁹⁹ and expresses bemusement over criticism of psychiatric risk assessment:

On the face of it, such opposition is a bizarre response to what amounts to nothing more than a special investigation. ... The best analogy is with intelligence quotient (IQ) testing.²⁰⁰

In that Maden is Professor of Forensic Psychiatry at Imperial College London, it is difficult to understand how he fails to appreciate the difference between the tests he describes and a test to assess dangerousness which may result in involuntary confinement for possibly a lengthy period. His description of such tests being an ‘*aide-mémoire*’ is difficult to reconcile with his willingness to “*add up the scores*”²⁰¹ and to thus allow a subject to “*be compared systematically with that of other patients ... allow us to position a patient on a scale.*”²⁰²

The most charitable description of Maden’s (2003a) attempted rebuttal²⁰³ of Szmulker (2001a) is that it is disingenuous;²⁰⁴ of Maden’s summary of his own argument²⁰⁵ – that

¹⁹⁶ *Ibid.*, p.132; the term ‘respondents’ refers to consultant psychiatrists.

¹⁹⁷ The PCL-R [Hare (1991)] test, for example, has as its first 5 (of 20) criteria:

- (i) Glibness / superficial charm;
- (ii) Grandiose sense of self-worth;
- (iii) Need for stimulation / proneness to boredom;
- (iv) Pathological lying;
- (v) Conning / manipulative; ...

[See Dolan & Doyle (2000), p.306].

¹⁹⁸ Higgins (2005), p.133.

¹⁹⁹ Maden (2003a) is an editorial entitled “*Standardised risk assessment: why all the fuss?*”

²⁰⁰ *Ibid.*, p.201; a more complete quotation is given in Appendix F.

²⁰¹ Maden (2005), p.122.

²⁰² Maden (2003a), p.201.

²⁰³ *Ibid.*, p.203:

The terminology of signal detection theory has been misused to argue that a 10% risk involves detaining nine false positives for every true one, resulting in the test having no value. But these instruments do not claim to identify offenders in advance, only to make statements of probability.

²⁰⁴ *Vide supra*: “... *do not claim to identify ... only to make statements of probability.*”

²⁰⁵ *Ibid.*, p.203:

it is confused. His *apologia*²⁰⁶ should merit the same response as would be given to any professional who, whilst acknowledging his lack of expertise in a particular area, nonetheless persisted in promoting his ‘expert opinion’ in that selfsame area.

Maden holds a position of authority and influence in British psychiatry and whilst his views may not be fully representative (*vide Szmukler supra*) it is reasonable to conclude that they are not wholly unrepresentative. In an editorial, Maden (2005) elaborates on the interests that he had sought to accommodate:

Certainly, blanket opposition to structured violence risk assessment is political or public relations suicide, and it invites outsiders to impose solutions upon us.²⁰⁷

Welsh & Deahl (2002) writing on ‘*modern psychiatric ethics*’, offer a different perspective on the duties placed on psychiatrists especially in relation to risk assessment:

... predictions of violence are highly subjective and seem at best unreliable and at worst “*imprecise ... and perhaps fruitless.*”...

... unreliable assessments of dangerousness of patients compromises the profession's position of acting beneficently, ... accusations of maleficent outcome are difficult to defend. The maxim “*above all do no harm*” has been ignored in the case of patients who are condemned to a limbo existence on crowded wards ...²⁰⁸

Welsh & Deahl (2002) concludes on a more general note:

Psychiatrists ... should not passively acquiesce to their role being defined by public policy makers, or, worse still, the media. ... psychiatrists should distance themselves from the perception that their allegiance is to public opinion.²⁰⁹

This admonition to their fellow psychiatrists can be more readily appreciated when viewed from a historical perspective: Soviet psychiatrists were rightly criticised for placing their own professional self-interest and the interests of their political paymasters, above the interests of their patients; can Professor Maden’s contention (*i.e.* that psychiatrists, for reasons of professional self-interest, should bend to accommodate

We have laws against speeding, not because of any certainty that a particular driver will have an accident, but because the probability of accidents is unacceptably high. A similar principle applies to violence associated with mental disorder.

²⁰⁶ *Ibid.*: “*Doctors have little experience of working explicitly with probability and they are not very good at it.*”

Maden’s plea is no more worthy of acceptance than that of a paediatrician who, having given an incorrect dosage of a drug to a child, sought to excuse himself on the grounds that he lacked the arithmetic skills necessary to determine the proportionate dosage (*i.e.* by comparing the bodyweights of an adult to that of a child).

Surely the paediatrician would be obliged to cease clinical practice until he achieved proficiency in the appropriate skills?

²⁰⁷ Maden (2005), p.121-2.

²⁰⁸ *Op. cit.*, p.254. [References omitted].

²⁰⁹ *Ibid.*, p.255.

the prevailing political winds even if this is, in fact, to the detriment of their patients) be distinguished from the Soviet practice?

Judged from an ethical perspective the dismissive attitudes of psychiatrists towards the likelihood of false positive assessments of dangerousness are difficult to distinguish from those who would seek to defend collective punishment. Consider the following thought experiment: an assailant who having killed his victim jumps into a crowded train; it is clear to the authorities that he is one of the 20 passengers in the train compartment but it is not possible to identify him from the other, innocent, passengers. Surely it cannot be argued that it is permissible to punish all 20?²¹⁰

C.2.2: Principle B and the ‘comparable risk’ problem

The MacArthur study²¹¹ was one of the most extensive and well funded studies of the links between mental disorder and violence ever undertaken. It was favourably²¹² reviewed by Maden (2003b) who summarised the results as:

Once substance misuse was excluded, patients did not have increased rates of violence and their violence followed the normal rules. The best single predictor of violence was personality disorder in the sense of psychopathy, ... Violence was also linked to alcohol, to previous violence and to neighbourhood context.²¹³

Mullen (2001) was equally impressed²¹⁴ by the MacArthur study and summarised its findings as: “*The best established mental health variable in predicting future offending behaviour is the presence of substance abuse.*”²¹⁵

Buchanan (2008) – whose survey of the literature was completed some seven years after Mullen (2001) is, accordingly, more comprehensive – concludes that: “*The predictive accuracy of even the simplest behavioral measures seems to exceed the predictive*

²¹⁰ Lest such a scenario might seem highly improbable, consider the US policy of targeted assassination; Wright (2010) comments:

... to fire missiles into cars, homes and offices in hopes of killing terrorists, while in fact killing no few innocent civilians. Estimates of the ratio of civilians to militants killed range all over the map – 50 to 1 or 10 to 1

Wright, R. (2010). ‘The high cost of political killing’. *International Herald Tribune*. 15 April.

²¹¹ Monahan (2001) *supra*.

²¹² Maden (2003b), p.237:

Over-funded, over-hyped, and over there. It is impossible for a British psychiatrist to look at the MacArthur study without a twinge, if not a spasm, of envy. ... There are few studies of outcome in psychiatry, and fewer still that mention violence. This is one of the few academic publications that will make, and deserves to make, money.

²¹³ *Ibid.*

²¹⁴ Mullen (2001), p.7: “*The MacArthur collaboration represents, in many ways, the most sophisticated examination to date of the relationship between having a mental disorder and violent and criminal behaviour.*”

²¹⁵ Mullen (2001), p.23; a more complete quotation is given *supra*.

power of diagnosis."²¹⁶ and gives, as examples, previous violent conviction (increases risk 14-fold) and substance abuse (increase risk 20- to 34-fold).

In the light of the findings that a previous history of violence or substance abuse or psychopathy are more robust predictors of violence than is psychiatric diagnosis or psychiatric risk assessment, it is of interest to review *Principle B* in relation to the possibility of involuntary detention of members of these other categories on the grounds of their dangerousness to others.

Previous history of violence

Under the Irish legal system, an individual who has a history of violent behaviour cannot, on that account alone, be detained to prevent future anticipated acts of violence irrespective of their likelihood. This prohibition on preventive detention extends to those with a criminal conviction and (up to 1997) even to applications for bail.²¹⁷ Professor Binchy,²¹⁸ writing about the legal steps that the State may take to prevent a person "*from acting in a way that will (or is likely to) cause harm to others*", states:

What is striking about the values that underlie the present position is the principle of restraint that is the common denominator. Thus we find that it is not an offence to intend to commit a crime, even where the intent can be proved beyond any reasonable doubt. ... That threshold is placed very close to the actual consummation of the offence. ... There are some extensions to this narrow proximity ... Recently, the Oireachtas has created a specific generic offence of endangerment.²¹⁹ It would be fair to say that the criminal law does not intervene into people's lives unless they choose actually to commit offences, attempt or conspire to do so or engage in conduct that itself is redolent of such an attempt or the likelihood of an unintended, recklessly induced harmful outcome.²²⁰

English law is less restrictive in this regard,²²¹ as is US law in relation to, for example, the detention of sex offenders subsequent to a term of imprisonment.²²²

²¹⁶ Buchanan (2008), p.187.

²¹⁷ Department of Health and Children (2002), p.230-1: Binchy states:

The Supreme Court has held, and reiterated its holding, that the likelihood that a person accused of an offence will engage in criminal conduct is not a reason for denying that person the entitlement to bail. To deny bail on the suspicion – even the well grounded suspicion – of future wrongdoing offends against the constitutional guarantee of liberty. This liberal stance of the Supreme Court ... was compromised by an amendment to the Constitution in 1997 ...

²¹⁸ Professor William Binchy is Regius Professor of Law at Trinity College, Dublin.

²¹⁹ *Non-Fatal Offences Against The Person Act* (1997):

S. 13. – (1) A person shall be guilty of an offence who intentionally or recklessly engages in conduct which creates a substantial risk of death or serious harm to another.

Such an offence would only be relevant to conduct presenting an imminent danger to others and is thus outside the scope of this discussion.

²²⁰ Department of Health and Children (2002), p.230.

²²¹ See, for example, Chiswick (1999).

²²² See, for example, Mansnerus, L. (2003). 'Questions Rise Over Imprisoning Sex Offenders Past Their Terms.' *The New York Times*. 17 November.

Substance abuse and personality disorder

Under Irish law, the *Mental Health Act* (2001), explicitly prohibits involuntary detention on the grounds of substance abuse or personality disorder.²²³

‘Previous conviction for an offence of violence’, ‘substance abuse’ and ‘personality disorder’ are each indicative of a higher level of risk of dangerousness to others than is a positive psychiatric risk assessment. However under Irish Law of these criteria, psychiatric risk assessment is the only one sufficient to ground an involuntary detention; this clearly violates *Principle B*.

As argued earlier, Principle B has a corollary concerning the personhood of those detained in violation of the principle; before drawing a conclusion from this corollary, a thought experiment may be of assistance.

A thought experiment

The use of profiling whereby members of racial or religious minorities – e.g. blacks or Muslims in the UK, Roma in Italy or Arabs in Israel – are (because of a disproportionately high level of violent crime in such minority communities) subjected to a heightened level of police intervention and detention, has proved controversial and has led to charges that the personhood of those minorities has been compromised. Would not these objections be immeasurably strengthened – and the conclusions rendered incontrovertible – if research had shown that these minorities presented a *lesser* incidence of violent crime than other groups in society who had been given legal immunity from such policies?

The fact that, under Irish Law, those who have been psychiatrically assessed as posing a danger to others can be involuntarily detained on the grounds of their dangerousness,²²⁴ whilst those belonging to other groups – e.g. those with a previous history of violence, or substance abuse or personality disorder – who pose a provably greater danger to

²²³ *Op. cit.*, s.8 [see Appendix A].

²²⁴ See Pierre (2009) who notes:

It comforts and reassures us that psychosis is at the root of these horrifying acts and that “*normal*” people did not commit them. We fantasize that if we can only better recognize and sequester the mentally ill, then we can keep our streets, schools, and countries safe.

See also comments by the chief of the UK Parole Board to the effect that large numbers of people remain in jail because society is too “*risk-averse*” to allow them to be released and that the public was “*perhaps unrealistic about the level of risk it should be prepared to accept*”. He pointed out that society had agreed it is wrong to deprive people of their liberty for something they might do.

Hill, A. (2010). ‘Parole chief: release more prisoners’. *The Guardian*. 31 March.

others, are legally exempt, implies that the personhood of those who are candidates for such psychiatric assessment, is diminished.²²⁵

Section D: Coercive ‘treatment’ in the interests of others

The issue to be discussed in this section concerns whether coercive ‘treatment’ can be administered to those who are detained on the grounds of their dangerousness to others; the correctness of whose detention having been conceded. Two cases fall to be distinguished:

- where the proposed treatment is independent of the grounds for detention *e.g.* treatment of a ruptured appendix where the subject lacks the capacity to consent,
- where the primary goal²²⁶ of the proposed treatment is to lessen the level of dangerousness exhibited by the subject.

Cases of the first type can be analysed within the Stage 1 framework (the existing coercive detention on the grounds of dangerousness being of no relevance); the analysis of cases of the second type is more problematic and is the focus of the current section. In relation to an individual detained because of the danger he poses to others, it is clear that restraint may sometimes be necessary. However, because of the serious and persistent nature of the harms²²⁷ that may be occasioned by prolonged use of chemical restraint [*e.g.* antipsychotics] a distinction must be drawn between the justification required for, on the one hand, the use of physical restraint or short periods of chemical restraint, and the justification for prolonged periods of chemical restraint; in particular, the fact that a subject’s ‘dangerousness to others’ may justify an involuntary detention and (physical) restraint does not of itself justify prolonged use of chemical restraint. The use of antipsychotics as a mechanism of restraint but administered under the guise of ‘treatment’ has been adverted to in the literature²²⁸ and earlier in this dissertation,²²⁹

²²⁵ See, for example, Thornicroft (2006), p.108:

Our popular images of madness are both long-standing and remarkably stable. One of the best established patterns is to refer to people with mental illnesses as the ‘polar opposites’ of us. In Western culture, for example, “[a] polar antiworld of human types has been developed, populated by the Black, the Jew, the Gypsy, the madman among others ... its source lies in the sense of distance between the perceiver and the perceived ... a distance imposed by the perceiver based on the anxiety generated by his perception.” [Gilman, S. (1982). *Seeing the Insane*. Wiley: New York.]

²²⁶ See the discussion *supra* on how, in relation to the coercive administration of drugs, ‘treatment’ is to be distinguished from ‘restraint’ by analysing the primary intent. If the primary intent is to restrain then any secondary intent is not relevant.

²²⁷ See Chapter 5.

²²⁸ See, for example, Matson & Wilkins (2008) *supra*.

See also Mullen (2001), p.36:

The danger is ever present in prisons that health professionals will succumb to pressures to provide inappropriate medications ... on the behest of staff pursuing the goal of a passive prisoner.

²²⁹ See, for example, the discussion on the use of antipsychotics as a ‘chemical cosh’ in Chapter 5.

as has the nature of the harms which may be consequent on their use; that these harms may be of such a nature as to entail a diminishment of personhood, will be discussed in Chapter 7.

An exploration of some comparable problems drawn from outside the field of psychiatry and a brief discussion of the Danish practice of restraining – but not ‘treating’ – those involuntarily detained on the grounds of their continuing dangerousness to others, will help isolate some guiding principles. The problems to be discussed are:

- the forcible treatment of TB patients who have been detained on the grounds of their dangerousness to others, [*Subsection D.1*]
- the castration of sex offenders who are near the end of their term of imprisonment but who pose a risk of reoffending on release. [*Subsection D.2*]

The Danish practice of restraint will be discussed in *Subsection D.3* and some conclusion will be drawn in *Subsection D.4*.

D.1: TB

The coercive treatment of those suffering from TB or other infectious diseases is discussed in Appendix B where it is concluded that the medical consensus is to the effect that, generally speaking, coercion is not appropriate; for example, the director of the UK’s TB research unit has stated:

To insist on compulsory treatment would be a step too far. Forced treatment would be just horrendous. I envisage a situation where six or seven muscly people have to hold a patient down for a period of half an hour in order to give them an injection against their will.²³⁰

It should be noted that the objections to coercive treatment did not rest on any suggestion that (unlike antipsychotics) the treatments were especially invasive in other than the coercive nature of their administration.

A similar reluctance to embark on coercive treatment is evident under Irish law.²³¹

D.2: Castration of sex offenders

The Czech Republic is the only country in Europe in which surgical castration is currently practised as a ‘treatment’ for sex offenders, it is carried out under the supervision of psychiatrists. In principle, the practice is voluntary but lawyers for the Council of Europe’s Anti-Torture Committee have cast doubts on whether, in the

²³⁰ See Appendix B for a more complete quotation.

²³¹ See the discussion in Appendix B concerning a legal challenge to the detention of a TB sufferer under the *Health Act* (1947); the Act contains no provision for compulsory treatment.

circumstances pertaining, the consent could be said to be freely given. The Committee deemed surgical castration “*invasive, irreversible and mutilating*” and demanded that the Czech Republic stop offering the procedure.²³² The introduction of a scheme of voluntary physical castration is under consideration in the UK.²³³

The chemical castration of sex offenders is not a novel procedure: in 1952 the logician Alan Turing was, for example, obliged as a condition for not being imprisoned on conviction for gross indecency, to undergo hormonal treatment.²³⁴ A number of European countries have either implemented or are either considering the introduction of consensual (Italy²³⁵, UK²³⁶, Spain²³⁷) or mandatory (Poland²³⁸) chemical castration for violent sex offenders.

D.3: The Danish experience

The Council of Europe Anti-Torture Committee reported in 2008 on the use by Denmark of techniques of restraint²³⁹ in relation to psychiatric patients who presented a serious and imminent danger to others. A psychiatrist speaking for the Committee stated:

²³² Bilefsky (2009): “A Danish study of 900 castrated sex offenders in the 1960s suggested the rate of repeat offenses dropped after surgical castration to 2.3 percent from 80 percent.”

Bilefsky, D. (2009). ‘Europeans Debate Castration of Sex Offenders.’ *The New York Times*. 10 March,

²³³ See, for example, Whitehead, T. (2009). ‘Sex offences advisor backs castration.’ *The Telegraph*. 20 May.

²³⁴ See, for example, Holt, J. (2006). ‘Code-Breaker: The life and death of Alan Turing’. *The New Yorker*. 6 February.

See also *The Independent* (2009):

The chemical castration caused his breasts to enlarge and bloated his athletic physique. He was also banned from travelling to America. What followed was described by his biographer David Leavitt as a “*slow, sad descent into grief and madness*” and Turing began travelling abroad in search of sex safe beyond the reach of the British law.

The Independent (2009): ‘The Turing enigma: Campaigners demand pardon for mathematics genius.’ *The Independent*. 18 August.

²³⁵ Channel 4 News (2008). ‘Castration for paedophiles call’. *Channel 4 News*. 19 February. [online], available: <http://www.channel4.com/news/articles/world/castration+for+paedophiles+call/1602952> [accessed: 23 June 2009].

²³⁶ *Supra*.

²³⁷ Channel 4 News (2008). ‘Castration offer for sex offenders’. *Channel 4 News*. 10 September. [online], available: <http://www.channel4.com/news/articles/world/castration+offer+for+sex+offenders/2449517> [accessed: 23 June 2009].

²³⁸ Bilefsky (2009) *supra*.

²³⁹ Isherwood (2008): “*Patients' arms were restrained in a belt around the stomach and a restraint around the legs ensured that the patient could only walk in short steps.*”

Council of Europe (2008), S. 124:

. . . As regards the Maximum Security Department of Nykøbing Sjælland Psychiatric Hospital, the use of prolonged physical immobilisation of patients was even more alarming. In one extreme case, a patient had been restrained to his bed for 6 months because of violent behaviour.

Isherwood, J. (2008). ‘Torture Comm.: Abuse of mentally ill.’ *Politiken.dk*. 24 November. [online], available: <http://i.pol.dk/newsinenglish/article601889.ece> [accessed: 24 June 2009].

There is no medical reason to restrain patients as much as you do in Denmark. We have never visited a country that uses strapping as much as in Denmark. This is an abuse of patients, ...²⁴⁰

The Report reiterated its earlier criticism:

In the 2002 visit report, the CPT stressed that applying instruments of physical restraint to psychiatric patients for days on end cannot have any medical justification and amounts, in the Committee's view, to ill-treatment.²⁴¹

Defending the use of restraints, the Chief Physician of one of the hospitals concerned, stated:

Patients who are so mentally ill and dangerous that they would otherwise be locked up are able to go to therapy and get fresh air using this type of restraint. ... We would prefer to treat our patients while they are relatively awake. That way they can better change their behaviour.²⁴²

If the goal in restraining a subject who is dangerous to others, is to minimise that danger in such a manner as to cause the least damage to the integrity of the subject, then surely – in cases where sustained restraint is necessitated – the use of physical restraint is preferable to a sustained coercive use of psychoactive drugs such as antipsychotics which may render the subject incapable of having an 'inner life'.

D.4: Conclusions

The objections to using coercion in the treatment of TB was based on two main concerns:

- that it would be counterproductive in that people would be hesitant to seek treatment if their being subjected to coercion was a possible outcome;²⁴³
- that the integrity of the human person is compromised by the use of such procedures.

The objection to using castration was that – even if apparently consensual – it occasioned too deep and intimate a trespass on the personhood of the subject; it is of interest to note that in defending the use of mandatory castration the Polish Prime Minister sought to depersonalise those subjected to it: "*I don't think you can call such*

²⁴⁰ Isherwood (2008).

²⁴¹ Council of Europe (2008), s.126.

²⁴² Isherwood (2008).

²⁴³ Precisely the same objection can be raised against the use of coercion in psychiatry especially in circumstances where a voluntary patient may easily be made involuntary; see, for example, Council of Europe (2008), s.140: "A voluntary stay in hospital may be transformed into an involuntary retention by the sole decision of the head doctor."

*individuals – such creatures – human beings, ... Therefore I don't think you can talk about human rights in such a case.*²⁴⁴

The objection to restraint was that it was degrading²⁴⁵ but it may well be that the act of placing someone under physical restraint creates an ongoing 'spectacle' endlessly creating the requirement that it be justified: the degradation is clearly manifest as is the need for its justification. The act of placing someone under chemical restraint creates no such spectacle: the subject who may, to himself, be like a "zombie", may present to others the image of peaceful sedation and contentment; the act of chemical restraint – particularly if it is called 'treatment' – may erase not alone the need, but even the call for justification. In this regard the Norwegian criminologist Nils Christie in writing about '*the shield of words*' notes that "*Words are a good means of disguising the character of our activities;*"²⁴⁶ as an example, he offers the term 'treatment':

But what could not justly be done in the name of punishment could not be objected to if it were carried out as treatment. Treatment might also hurt. But so many a cure hurts. And this pain is not intended as pain. It is intended as a cure. Pain becomes thus unavoidable, but ethically acceptable.²⁴⁷

I wish to draw the following conclusions from the preceding discussion:

- 1. The prolonged use of psychoactive drugs as a mechanism of restraint (whether or not described as 'treatment') may be more invidious than physical restraint in that it trespasses on the psyche of the subject; moreover, in being less visible, it is less susceptible to scrutiny and the requirement that it be justified.*
- 2. Whereas a coercive psychiatric intervention (e.g. detention or restraint) may, in some circumstances, be justified by the interests of others, these interests do not justify additional coercive measures under the guise of psychiatric 'treatment'.*

In the following chapter it will be argued that the prolonged coercive use of particular psychoactive medications (such as antipsychotics) may be so invasive of the 'innermost being' of the subject as to entail a diminishment – or possible destruction²⁴⁸ – of their personhood.

²⁴⁴ Boyles, R. (2008). 'Chemical castration for sex offenders in Poland.' *The Irish Independent*. 26 September.

²⁴⁵ Council of Europe (2008), s.128.

... the patient's arms were attached to a belt and the feet attached to each other by straps, thus permitting the patient to walk around while remaining physically restrained. Such a form of physical immobilisation could be considered as degrading.

²⁴⁶ Christie (1981), p.3.

²⁴⁷ *Ibid.*, p.6; he takes 'drunkenness' as an example and shows how its 'treatment' rather than its punishment enabled the use of harsher methods of management.

²⁴⁸ As sometimes occurred with the use of surgical lobotomy and is alleged to occur with particular psychoactive medications ['chemical lobotomy'].

Chapter 7: Coercive psychiatric interventions and damage to personhood

*Alice could not help her lips curling up into a smile as she began:
“Do you know, I always thought Unicorns were fabulous monsters, too! I never saw one alive before!”
“Well, now that we have seen each other,” said the Unicorn, “if you’ll believe in me, I’ll believe in you. Is that a bargain?”*

from Lewis Carroll ‘Through the Looking Glass’¹

As discussed in the Introduction, the concept of ‘personhood’ plays a fundamental role in the formulation of the argument being advanced in this dissertation. A number of possible meanings of the term were distinguished: ‘Personhood_{ETH}’, ‘Personhood_{POL}’, ‘Personhood_{SOC}’ and ‘Personhood_{LAW}’. Each of these meanings relates to a particular context within which the term is to be understood; thus, for example, Personhood_{ETH} connotes an ethical or philosophical context and delineates those individuals who, judged from a philosophical perspective, are ‘persons’;² whereas Personhood_{SOC} relates to a sociological context and, in a particular society, distinguishes between those individuals who are generally regarded as ‘persons’ from others who suffer social exclusion (being generally regarded as ‘outcasts’ or ‘non-persons’). To enable the formulation of the argument, three postulates³ were adopted, the first two of which were to the effect that Personhood_{ETH} can be specified by a set of necessary and sufficient

¹ See Carroll (2010), p.103.

² The term ‘personhood’ (in a philosophical or ethical context) is being used in the narrow technical sense outlined in Chapter 1 where the following was noted:

... the proposition that ‘X has personhood_{ETH}’ is equivalent to stating that X objectively satisfies the conditions for personhood and, in consequence, objectively possesses Rights-Cluster_{ETH}; strictly speaking, X’s subjective conviction that he is in full possession of Rights-Cluster_{ETH} (and thus has Personhood_{ETH}) is a distinct concept meriting a separate symbol such as Personhood_{ETH-SUBJ} (with an associated Rights-Cluster_{ETH-SUBJ}) but to introduce such a symbol would further complicate an already complex analysis for little additional benefit. Accordingly in the discussion to follow, unless the concepts need to be distinguished, Rights-Cluster_{ETH} will be understood as also referring to Rights-Cluster_{ETH-SUBJ} (and Personhood_{ETH} as also referring to Personhood_{ETH-SUBJ}); the justification being that if X has a deep and sustained conviction, born of long experience, that he lacks Rights-Cluster_{ETH}, the (philosophical) assertion that he does not – as distinct from asserting that he *should* not – would appear to be needlessly gratuitous.

³ See Chapter 1:

Postulate 1. Personhood can be defined by a set of necessary and sufficient conditions which include criteria as to minimum levels of rationality and ability to communicate.

Postulate 2. From amongst such sets of conditions, a set is chosen such that the only conditions relevant to justifying a coercive psychiatric intervention, are ‘rationality’ and ‘ability to communicate’.

Postulate 3. [Foot (1977)] The ascription of personhood confers a rights-cluster the most fundamental of which is ‘the right to life’; a key element of the right to life is the ‘right to be let alone’.

conditions which include criteria as to minimum levels of rationality and ability to communicate, these being the only conditions in the set which are relevant to justifying a coercive psychiatric intervention.

‘Personhood_{ETH}’ – unlike the other meanings identified above – is an all-or-nothing condition⁴ *i.e.* an individual is, or is not, a person and accordingly, though one can speak of the *destruction* of Personhood_{ETH}, one cannot speak of its *diminishment*.⁵ Personhood_{SOC}, in contrast, permits gradations⁶ and thus one could speak of the Personhood_{SOC} of an individual being diminished by the act of another as, for example, might occur by the spreading of untrue, but damaging, rumours that they suffered from a highly infectious disease.

‘Person’ – as a generic term – connotes an owner of rights and, correspondingly, each meaning of the term identified above is associated with its respective ‘rights-cluster’; thus, for example, Rights_{SOC} corresponds to those rights which, by social consensus, are regarded as intrinsic to being a person; these rights would be identified by means of statistical surveys of social attitudes.

Rights_{ETH}, in contrast, denotes those rights grounded in the philosophical or ethical concept of a person. These rights fall to be determined by a logical analysis of personhood; of these rights – as argued by Foot (1978) and adopted⁷ in this dissertation – the ‘*right to be let free from unwanted interference*’ is one of the most fundamental⁸ and distinctive.⁹ A coercive psychiatric intervention undertaken in the face of a subject’s objections is, *prima facie*, a breach of this right. However, as was argued in earlier chapters, some interventions may be of such a minor nature as to be more in the nature of trespasses on the right than fundamental breaches¹⁰; conversely – as will be argued below – other coercive psychiatric interventions may be so intrusive and extensive as not only to violate, but to effectively destroy that right. The terms ‘destruction of personhood’ and ‘diminishment of personhood’ have been used in earlier

⁴ Strictly speaking this is so only at a particular period in time; the situation may change at a later time as when a patient who is in a vegetative state, subsequently recovers. Such cases require a more subtle analysis; see also Roche (2000).

⁵ Though psychoactive medication which severely hindered a subject’s ability to communicate might merit this description [*vide* Manweiler’s description (*supra*) of being like a “zombie”] as could Personhood_{ETH} when understood in its subjective sense as Personhood_{ETH-SUBJ} (see *supra* and Chapter 1).

⁶ As does Personhood_{LAW}.

⁷ See *Postulates 3 (supra)*.

⁸ Note that the argument being developed here relates to the *Stage 1* argument; issues relating to dangerousness are the concern of the *Stage 2* and *Stage 3* arguments.

⁹ Foot argued that this right took precedence over “... [any] *action we would dearly like to take for his sake.*” See Foot (1977), p.102.

¹⁰ Such interventions will be discussed more fully in the Conclusions.

chapters and will be explained more fully below, but first the term ‘destroyed’ requires some clarification.

The term ‘destroyed’

As discussed in the Introduction, when one says that a house has been ‘destroyed’ by a storm or fire one does not mean that every trace of the original house is gone or that no brick is left standing, rather one means that, although vestiges of the house may remain and hints of its original structure may still be glimpsed, it is so severely damaged that, realistically, no remedial work could restore it to its original condition; it is damaged beyond repair, destroyed. It is in this sense that the term is used in speaking about a coercive psychiatric intervention *destroying* a subject’s personhood, especially in the context of Personhood_{SOC}.

Accepting (for the sake of argument) that some coercive psychiatric interventions may be such as to effectively destroy a subject’s personhood, the question arises as to how such interventions might be justified. If the subject in question exhibited such a level of irrationality or inability to communicate as to breach the criteria for personhood – as, for example, might occur in severe dementia or catatonic schizophrenia – then the full complement of rights associated with Personhood_{ETH} would not have been operative;¹¹ in such circumstances, and providing the intervention was carried out in the best interests of the subject,¹² no additional justification¹³ would be required. However, when judged against many of the examples of coercive psychiatric interventions given earlier,¹⁴ the prevalence of irrationality and inability to communicate at levels sufficient to put Personhood_{ETH} at risk, appears to be the exception.

The ‘destruction’ and ‘diminishment’ of personhood consequent on a coercive psychiatric intervention

A coercive psychiatric intervention may have the result that a subject, whose personhood was not in doubt prior to the intervention, is left unable to communicate as has occurred when, for example, a lobotomy resulted in a subject becoming a ‘vegetable’. Such an eventuality may be of a seriousness sufficient to irreversibly destroy the ‘ability to communicate’; in such circumstances the intervention could be described as the *destruction* of Personhood_{ETH}.

¹¹ In particular, “*the right to be let free from unwanted interference.*” [Foot (*supra*)].

¹² Or, in Foot’s analysis, in accord with the obligations of charity.

¹³ Though see Chapter 5 in relation to the administration of pharmaceutical treatments.

¹⁴ For example, the Manweiler and Juklerød cases.

A coercive psychiatric intervention may so grievously breach the ‘right to be let alone’_{LAW} that the right may have been effectively destroyed; this is especially the case in that the (Irish) courts show great reluctance to challenge the opinion of a psychiatrist regarding involuntary committal; this, in turn, makes the prospect of a successful challenge to any future committal even less likely. In consequence, the subject may well perceive their ‘right to be let alone’_{LAW} – and hence their Personhood_{LAW} – to have been if not destroyed, then grievously diminished.¹⁵

A coercive psychiatric intervention may put not only the Personhood_{ETH} and Personhood_{LAW} of a subject in jeopardy, but also their Personhood_{SOC} *i.e.* the intervention may so grievously stigmatise the subject in the eyes of their peers that their personhood (in the sense of lived experience of being treated with dignity and respect and as an equal) may be grievously diminished. It may well be that such diminishment is caused not by the coercive psychiatric intervention itself, but by the prior circumstances which precipitated the intervention but, where this is not the case and where the diminishment is severe then the requirement for justification may be no less onerous than in cases where Personhood_{ETH} is destroyed because, to the individual, it is the lived experience of personhood (*i.e.* Personhood_{SOC}) rather than its philosophical meaning (*i.e.* Personhood_{ETH}) that is of supreme importance.

The following diagram [Table 7-1] may help clarify some of the issues discussed in the preceding paragraphs.

¹⁵ This is not to deny that he may have the enforceable right to stop other, non-psychiatric, intrusions.

‘survivors’¹⁹ who have described the effects of such intervention on their ongoing sense of self as being autonomous persons entitled to respect and dignity. *Section D* draws some conclusions from the preceding discussion.

Section A: Non-psychiatric radical interventions

In this section, I wish to consider three examples of gross interventions into the life of another:

- the use of rape as a weapon of war [*Subsection A.1*];
- the psychiatric incarceration of political dissidents [*Subsection A.2*];
- a case of forcible non-psychiatric treatment [*Subsection A.3*].

I then examine whether points of comparison exist between these examples and cases of coercive psychiatric intervention [*Subsection A.4*]; to assist in the development of the argument it will first be assumed that the psychiatric intervention has been precipitated by a psychiatric misdiagnosis, this restriction will be subsequently removed.

A.1: Rape as a weapon of war

Since time immemorial rape has been a concomitant of war, however its use as a strategy of war appears to be a recent development and was a hallmark of the 1993 Serbian conflict.²⁰ Since then there have been reports of it being used in many African conflicts and, most recently, in Sudan.²¹

Amnesty has reported that rape is a cultural taboo in Sudan and that the victims are ostracized by their families:

The suffering and abuse endured by these women goes far beyond the actual rape, ... Rape has a devastating and ongoing impact on the health of women and girls, and survivors now face a lifetime of stigma and marginalization from their own families and communities.

“Five to six men would rape us in rounds, one after the other for hours during six days, every night,” the woman, who was identified only as S., told Amnesty researchers. *“My husband could not forgive me after this; he disowned me.”*²²

There are reports that the rapes are often accompanied by mutilation²³ thus ensuring that the shame is made manifest to all – a stigma accentuated by the refusal of the local authorities to vindicate the rights of the rape victims.²⁴

¹⁹ ‘Survivor’ is the self-descriptive term preferred by those ex-patients who campaign against forced psychiatric treatment; see, for example, Emerick (2006).

²⁰ Kristof, N. (2008). ‘The weapon of rape.’ *The New York Times*. 15 June.

²¹ Lacey, M. (2004). ‘Amnesty Says Sudan Militias Use Rape As Weapon.’ *The New York Times*. 19 July. There have also been reports of rape being used in the Congo as a weapon against males: Gettleman, J. (2009). ‘Symbol of Unhealed Congo: Male Rape Victims.’ *The New York Times*. 4 August.

²² Lacey (2004) *supra*.

²³ Kristof (2008) *supra*.

A.2: The psychiatric incarceration of political dissidents

The practice of detaining political dissidents in psychiatric hospitals and subjecting them to ‘treatment’ with psychoactive medications has, in relation to the former USSR²⁵ and China,²⁶ been well documented.

Leonid Plyushch, who was one such dissident, was detained in a psychiatric hospital and forcibly medicated with antipsychotics. He has given a harrowing account of the extent of his intellectual and emotional deterioration whilst being administered antipsychotics.²⁷

A.3: A case of forcible non-psychiatric treatment

Writing in the *New England Journal of Medicine* on the topic of ‘Legal issues and Medicine’, the jurist and bioethicist George Annas²⁸ criticised the then newly introduced regulations concerning the use of restraint in medical emergencies. To add weight to his argument he cited a case then recently decided by the Massachusetts Supreme Court which concerned the 29-year-old daughter, Catherine, of an English physician who, in 1990, suffered a severe asthma attack whilst staying with her sister, Anna, in the United States. She had suffered from asthma most of her life and was well informed as to its management; Annas continues:

Anna suggested that they go to Massachusetts General Hospital. Catherine agreed, but only if her treatment would be limited to the administration of oxygen. Anna called the hospital and was assured that Catherine would be treated only with

... [Z] had been kidnapped, gang-raped, mutilated - slashed with a sword on her leg - and then left naked and bleeding to wander back to her Zaghawa tribe. In effect, she had become a message to her people: Flee, or else.

²⁴ Hoge (2005):

Local authorities will not acknowledge the magnitude of the problem, he said, and people who do call attention to it are “*not only not praised, they are castigated.*” He cited the cases of two members of Doctors Without Borders who documented 500 cases of rape in the Darfur region of Sudan, a number he estimated as only a fraction of the total. The two were arrested by Sudanese authorities and charged with spying.

Hoge, W. (2005). ‘U.N. Relief Official Condemns Use of Rape in African Wars.’ *The New York Times*. 22 June.

²⁵ Bloch & Reddaway (1984); see also Chapter 4 *supra* and Appendix L.

More recent allegations in relation to Russia are detailed in Gee, A. (2007). ‘Russian dissident ‘forcibly detained in mental hospital.’ *The Independent*. 30 July.

²⁶ See, for example:

– Minsky, J. (2003). ‘China’s Psychiatric Terror.’ *The New York Review of Books*. 50(3): 27 February.

– Kahn, J. (2006). ‘Sane Chinese Put in Asylum, Doctors Find.’ *The New York Times*. 17 March.

²⁷ See Chapter 5 (*supra*):

I was horrified to see how I deteriorated intellectually, morally and emotionally from day to day. My interest in political problems quickly disappeared, then my interest in scientific problems, and then my interest in my wife and children.

²⁸ George J. Annas is the Edward R. Uteley Professor of Health Law, Bioethics & Human Rights, Chairman of Department of Health Law, Bioethics & Human Rights, at the Boston University School of Public Health as well as Professor in the university’s schools of Medicine and Law.

oxygen. They went to the emergency department at 7 a.m., where Catherine was given oxygen and medication through a nebulizer. Catherine soon removed the nebulizer, reporting that the medication gave her a headache, and said she wanted to leave the hospital.²⁹

The attending physician concluded that intubation was necessary; meanwhile Anna telephoned their (physician) father who spoke with the attending physician and told him “... that Catherine understood her illness well and that he should listen to her and not treat her without her consent.”³⁰ Catherine attempted to leave the hospital but was forcibly placed in a four-point restraint, although “No one ever questioned Catherine's competence to consent to treatment, nor was there any basis to question her competence.”³¹

Evidence was later presented to a court that Catherine:

... had been severely traumatized by her mistreatment at the hospital. She had nightmares, cried constantly, was unable to return to work for several months, became obsessed about her medication, and swore repeatedly that she would never go to a hospital again.³²

Some two years after the original incident she again had a severe asthma attack; she refused to go to hospital and subsequently died. After her death, legal proceedings were taken by her father in relation to the original incident; the trial judge held for the hospital authorities but this was reversed on appeal and the judgement reaffirmed and restated the pre-existing law which had been ignored by the inferior court:

Competent patients, however, cannot be forced either to talk or to listen, and the fact that they will not talk to the physician does not by itself make them incompetent, any more than the fact that they do not agree with the physician's recommendation. Catherine Shine, as a competent adult patient, also had a legal right to leave the hospital at any time she decided to leave.³³

The publication of Annas (1999) elicited a number of replies from medical practitioners who unanimously expressed the opinion that the decision of the original physician to use coercion, was correct:

(i) *Sklar*: I usually tell residents to err on the side of saving a life and protecting themselves rather than protecting a patient's autonomy, when there is serious concern about a patient's decision-making capacity during refusal to receive potentially lifesaving treatment.³⁴

²⁹ Annas (1999), p.1409.

³⁰ *Ibid.*

³¹ *Ibid.*

³² *Ibid.*

³³ *Ibid.*, p.1411.

³⁴ Sklar (2000).

(ii) *Hansen-Flaschen*: ... under extraordinary circumstances such as those confronted by Dr. Vega in the care of Catherine Shine, physicians are best advised when in doubt to err on the side of life.³⁵

(iii) *Migden*: In a recent article, Gawande told the story of a young patient who refused intubation ... He was intubated despite this refusal. His first words after being extubated were "thank you." How many such outcomes are needed to justify future decisions to intubate patients like Catherine Shine?³⁶

(iv) *Janofsky*: Catherine Shine's behavior (running out of the emergency room without warning) and her medical condition at presentation ... indicate a substantial probability that her capacity to make informed decisions was impaired.³⁷ ... How could the physician in this case have continued the discussion if the patient had been allowed to run out of the hospital?³⁸

Catherine Shine's father – who commended Annas for his account of the events – added a detail:

Being held in four-point restraints in a supine position for almost an hour before intubation and for eight hours afterward troubled Catherine greatly because the humiliation and discomfort were compounded by her impression that restraints were used as a punishment, an opinion shared by at least one member of the hospital staff.³⁹

Annas (2000) replying to the correspondence, noted:

All the correspondents except her father seem unable to accept the law and seem to want a return to the practice of old-time medical paternalism instead. ... Migden thinks that the fact that some patients on whom treatment is forced have later thanked their physicians justifies forced treatment. But this is not true and in any event has no relevance ... Treatment is legal and ethical at the time it is administered; it does not become illegal and unethical simply because a patient either dies or says "I wish you hadn't done that."⁴⁰

A.4: The analogy with coercive psychiatry

Two questions arise:

- (i) *Do the examples portray the destruction or diminishment of personhood?*
- (ii) *Can these examples offer any insight into the use of coercion in psychiatry?*

³⁵ Hansen-Flaschen (2000).

³⁶ Migden (2000).

³⁷ A view explicitly rejected by the Appellate Court (*supra*) as was the suggestion that the physician has a right to insist that the discussion continue.

³⁸ Janofsky (2000).

³⁹ Shine (2000).

⁴⁰ Annas (2000).

An interesting confirmation of Annas's point concerning the ethical irrelevance of any subsequent assent is given in an essay on Arthur Koestler by the psychiatrist Theodore Dalrymple who – in discussing reports that Koestler had been guilty of a number of rapes of women who subsequently "remained friends with him for the rest of their lives" – examined Koestler's novel *Darkness at Noon*. The 'hero' of the novel, Slavek, rapes Odette:

After it is all over, Odette cries. Slavek takes her hand, and feels encouraged when she does not withdraw it to explain and justify his actions: "You know, I am not so sure that you will always regret it, although for the moment you are still angry with me."

Dalrymple (2007) comments: "And to confirm the Slavek-Odette-Koestler theory, Slavek and Odette go on to have a short and intense love affair."

The examples will be discussed *seriatim*; but first a point of clarification is necessary: to assert that the breach of an individual's right to be let alone was of such a magnitude as to cause the 'destruction' of their personhood implies that the intrusion was so intimate, so sustained, so pervasive (such as, for example, involving the participation or agreement of state agencies) and so irremediable that – when judged from the perspective of the subject⁴¹ – their right to be let alone was destroyed; it is not necessary that the right be either universally or continuously violated.⁴²

A.4.1: Sudanese rape victim

A case of rape in a modern western society – though an extreme example of a breach of the right to be let alone – is nonetheless usually an isolated event and the victim has recourse to a legal system to seek redress and vindication; thus such a breach could not be categorised as a 'destruction' of the right to be let alone. The Sudanese victim of rape, in contrast, has no such recourse to the courts with the result that she could be violated with impunity and to an extent that one might rightly say that her right to be let alone – and consequently her Personhood_{ETH} (in the subjective sense) – was destroyed.⁴³ Furthermore the stigma and ostracization visited on a Sudanese rape victim by her community is such that her Personhood_{SOC} can be said to be grievously diminished.

A case⁴⁴ of the use of coercive psychiatry in the furtherance of a forced Bangladeshi marriage, offers some parallels. In 2008 Dr. Humayra Abedin, who was practising as a medical doctor in London, was lured back to Bangladesh having been told that her mother was dangerously ill. On her arrival she was held captive by her parents because, in their eyes, she was "*too independent*" and she was coerced into accepting an arranged marriage. She was sedated and kept imprisoned in the family home for four months and subsequently transferred to a psychiatric hospital where she was forcibly medicated with antipsychotics. She described the effect of these drugs: "*My hair was falling off ... I had tremors ... When I was walking I looked like a robot ... I couldn't stand for a long*

⁴¹ *I.e.* Personhood_{ETH} in the subjective sense (Personhood_{ETH-SUBJ}).

⁴² *I.e.* the recognition of the right to be let alone by others, or at other times, being not sufficient to overcome the invasiveness of the original violation nor, especially, the possibility of its reoccurrence.

⁴³ The situation of an undocumented immigrant in Europe or the US, who has been raped but who, because of their lack of status, can neither seek medical help nor legal redress, is perhaps comparable to that of the Sudanese rape victim.

⁴⁴ The details of the case are taken from Channel 4 News reports of 14 December 2008; 19 December 2008 and an extended interview with Dr. Abedin: Turton, S. (2009). 'Exclusive: forced marriage victim speaks.' *Channel 4 News*. 13 July. [online], available: <http://www.channel4.com/news/articles/uk/exclusive+forced+marriage+victim+speaks/3264177> [accessed: 15 July 2009].

time.”⁴⁵ She was forced to participate in a marriage ceremony whilst medicated and in a near-somnolent state. The UK High Court issued a protection order under the *Forced Marriage (Civil Protection) Act* (2007) which – though it was without legal force – had a persuasive effect on the Bangladeshi courts which ordered her release and the commencement of nullity proceedings. In such circumstances the breach of her right to be let alone would stand comparison to that of the Sudanese rape victim and might equally merit the assessment that Dr. Abedin’s Personhood_{ETH} (in the subjective sense) and Personhood_{LAW}⁴⁶ had been destroyed.

It is relevant to note that her success in ‘escaping’ from an arranged marriage might have had radically different effects on her Personhood_{SOC} depending on whether it was judged from within Bangladeshi (her actions showed deep disrespect of family and social traditions, leading perhaps to some social ostracization) or within English society (her actions being worthy of commendation).

A.4.2: Leonid Plyushch

Bloch & Reddaway (1984) eloquently describe the effects of Plyushch’s incarceration:

Putting aside momentarily the sheer horror of a mentally-well person being forced into a psychiatric hospital.⁴⁷

Added to this frightening insecurity is the sense of complete impotence experienced by the dissenter. Not only is he deprived of the right to judicial review but he also has no legal redress whatever concerning any aspect of his conditions. For example, he cannot mount a malpractice suit against a cruel staff member ...⁴⁸

Plyushch’s description of the effects of antipsychotics on his inner life has been given earlier⁴⁹; this violation and destruction of his inner life could perhaps be compared to that of the Sudanese rape victim in that firstly, the violation of a subject’s mind, leading to a degradation of their intellect and consciousness, is perhaps an even more intimate violation than the violation of their body.⁵⁰ Secondly, like the Sudanese rape victim, Plyushch – in that the state was his violator – was unable to seek the sanctuary of the state’s legal system. For these reasons it is possible to conclude that his Personhood_{ETH} (in the subjective sense) was destroyed.

⁴⁵ Turton (2009).

⁴⁶ The involvement of the UK court was purely fortuitous and it would seem that in its absence, Dr. Abedin would have been remediless. Dr. Abedin reported that many women in circumstances similar to hers were being confined in the psychiatric hospital, women whom she believed to be ‘normal’.

⁴⁷ *Op. cit.*, p.26.

⁴⁸ *Ibid.*, p.29.

⁴⁹ Campbell (1976) described the harm done to Plyushch as being “a threat to ‘the precious inner life of man’.”

⁵⁰ The magnitude of the jury award in the Manweiler case (Appendix H) provides evidence in support of such a comparison.

Plyushch, having been diagnosed as suffering from a psychiatric disorder, his competence to communicate rationally or to speak as an equal to another, were placed in doubt; his opinions and arguments were liable to be ignored by others and taken as the ramblings of a disordered mind. It is unclear whether in the particular political situation that existed in the USSR at that time, this stigma would have extended to the wider Soviet society; if it did then Plyushch's Personhood_{SOC} would have been diminished.

In describing Plyushch's situation, Bloch & Reddaway (1984) comment that: "*The prospect of being placed compulsorily in a psychiatric hospital as a healthy person is so ghastly as to be almost unimaginable.*"⁵¹

The irony is that the authors seem unaware that precisely the same horror can be evoked by contemplating the situation of anyone wrongly committed and forcibly treated in any Western European psychiatric hospital; it has been shown in Chapter 4 that such cases exist; the Manweiler case being one such,⁵² the Juklerød case⁵³ is another.

Bloch & Reddaway (1984) attempt⁵⁴ to distinguish the use of Haldol by western psychiatrists [*"conscientious psychiatrist's caution ... scrupulous attention to ... dosage"*] from that by Soviet psychiatrists [*"... indiscriminate use of these drugs"*]; but Plyushch's own description⁵⁵ contradicts these assertions and makes reference to being given "*small doses*" of haloperidol. Furthermore, his description of the effects of antipsychotics is similar to the descriptions given by Manweiler and Juklerød (*supra*) of the effects of antipsychotics coercively administered by western psychiatrists.

It is also of note that Juklerød's detention was prolonged because he refused to acknowledge that his original beliefs⁵⁶ were erroneous; a similar insistence on recantation was required in the USSR:

"Release requires recantation" might well be their slogan. As Vladimir Bukovsky describes it: "*. . . admit openly and officially to the doctors that you were sick – yes, I was ill, yes; I didn't know what I was doing when I did it. The second condition is to admit you were wrong, to disavow what you did.*"⁵⁷

⁵¹ Bloch & Reddaway (1984), p.29.

⁵² See Appendix H where it was noted that Manweiler was enabled to bring legal proceedings only by virtue of a purely fortuitous set of circumstances.

⁵³ See Appendix G.

⁵⁴ *Op. cit.*, pp.27–28.

⁵⁵ *The New York Times* (1976) (*supra*).

⁵⁶ See Appendix G; Juklerød had argued that local schools were being closed in breach of the law.

⁵⁷ Bloch & Reddaway (1984), p.28.

Of which, Bloch & Reddaway (1984) comment:

... At first sight we might regard Plyushch and his ilk as unduly stubborn, too highly principled, unrealistic. But we need to pause ... Imbued with idealism and dedicated to their convictions, be they social, political or religious, they see recantation as tantamount to self-abnegation, to spiritual death: "*moral suicide*" is Fainberg's apt label.⁵⁸

But such unwillingness to suffer self-abnegation was also the wellspring of Juklerød's refusal.⁵⁹

In conclusion, it would seem that the strict demarcation which Bloch & Reddaway (1984) attempt to draw between the situation encountered between cases such as Plyushch's and cases of coercive psychiatric detention and coercively administered antipsychotics⁶⁰ in western psychiatric hospitals where the intervention was precipitated by a psychiatric misdiagnosis, is not well founded and that the destruction of Personhood_{ETH} (in the subjective sense) and the diminishment of Personhood_{SOC} and Personhood_{LAW} would apply equally to the latter.

However, the incorrectness of the diagnosis is not the decisive issue because if the coercive psychiatric intervention was such as to destroy Personhood_{ETH} (in the subjective sense) or grievously diminish Personhood_{SOC} and Personhood_{LAW}, then the correctness of the precipitating diagnosis cannot, of itself, justify these consequences; for that to occur it must be shown that, in relation to the circumstances of the subject at the time of the intervention, either the rationality or the ability to communicate, criterion for personhood had not been satisfied.

A.4.3: Catherine Shine

Judged from a disinterested perspective, the wrong done to Catherine Shine – though grievous – might appear to be such as not to have put her personhood under threat in that it related only to the management of a specific medical conditions (asthma) in one particular hospital.

Judged from the perspective of Catherine Shine, the humiliation and punishment which she suffered and the fact that the intervention left her "*severely traumatized*" points to the severity of the violation to which she believed she had been subjected. Her vow

⁵⁸ *Ibid.*

⁵⁹ See Appendix G.

⁶⁰ See also the United States Senate hearings in 1977 into human drug testing by the CIA where: The Deputy Director of the CIA revealed that over 30 universities and institutions were involved in an "*extensive testing and experimentation*" program which included covert drug tests on unwitting citizens "*at all social levels, high and low, native Americans and foreign.*" Several of these tests involved the administration of LSD to "*unwitting subjects in social situations.*" Committee on Human Resources (1977).

“never go to a hospital again” – a decision which resulted in her death – suggests that she believed the violation to be irremediable and that a court application would not have vindicated her rights.⁶¹ Based on such grounds – and the fact that her rationality was never compromised⁶² – it could be argued that the coercive intervention did destroy her Personhood_{ETH} (in the subjective sense) in that she had become ‘one to whom things are done’, bereft of the right to be let alone.

It is doubtful if the events in the hospital could be said to have had any effect on her Personhood_{SOC}.

Paternalistic attitudes leading to interventions comparable to those suffered by Catherine Shine are common in Irish psychiatric practice both in regard to the coercive treatment of those who are competent to refuse treatment [A.4.3.1], and in regard to clinical (and sometimes judicial) disregard for statutory provisions designed to safeguard the rights of those detained under the provision of the Mental Health Acts [A.4.3.2].

A.4.3.1: Coercive psychiatric treatment of those competent to refuse

Discussing the use of ECT under Irish Mental Health legislation, a legal academic has posed the question:

... is it appropriate for the law to permit the provision of ECT to a legally competent, resistant adult? While some patients with mental disorders may not have the competence to make treatment decisions, many do. Section 59 of the *Mental Health Act 2001* currently allows ECT to be administered to “unwilling” patients regardless of their legal competence.⁶³

The imposition of ECT on a competent patient against their wishes is surely of comparable – if not greater⁶⁴ – invasiveness than forced intubation; if the latter was sufficient to destroy Personhood_{ETH} (in the subjective sense) then, *a fortiori*, so is the coercive administration of ECT.

⁶¹ A belief which, to some extent, was vindicated by the decision of the court of first instance.

⁶² Contentions such as Janofsky’s (2000) (*supra*) that Shine’s rationality was in doubt was not accepted by the court and is reminiscent of Amy’s physician’s observation [Appendix C]: “... the current test of rationality was often concurrence with the opinions of one’s physician”.

⁶³ Donnelly, M. (2008). ‘Letters to the Editor: Patients’ rights and ECT.’ *The Irish Times*. 7 June; she continues:

The protections afforded to patients under the *Mental Health Act 2001* in this respect are inadequate. While the imposition of ECT on an “unwilling” or “incapable” patient requires a second opinion, the Act specifies that the second opinion must be obtained from a consultant psychiatrist to whom the matter has been referred by the patient’s own consultant psychiatrist (who prescribed the treatment in the first place).

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⁶⁴ In that the coercive administration of ECT is invasive not only of the body, but of the mind of a subject.

A.4.3.2: Widespread disregard for the provisions of the Mental Health Acts

The behaviour of consultant psychiatrists is examined in [A.4.3.2.1](#); and of the Superior Courts, in [A.4.3.2.2](#).

A.4.3.2.1: Consultant psychiatrists

A disquieting aspect of the Shine case is that even when the courts had made the legal position abundantly clear,⁶⁵ this was not accepted by any of the medical specialists who commented (*supra*) on Annas (1999) and who appeared to regard a clear statement of the law as of little consequence when confronted with clinical ‘certainties’. Similar attitudes are to be found amongst Irish consultant psychiatrists; for example, a *Report of the Inspector of Mental Health Services*, states:

Consultants, in particular, had a tendency to view the documentary requirements as “*mere technicalities*” in many cases. Some consultants failed to understand the legal nature of the requirements, while others were unaware of the basis of these requirements in the State’s human rights commitments. A number failed to view the matter from the perspective of the service users, who have a right to involvement in their treatment and to an integrated treatment plan. In many cases, it was a matter of “*we’ve always done it this way*”.⁶⁶

A further example is provided by one of Ireland’s most eminent psychiatrists⁶⁷ who – in discussing the Manweiler case – elaborated on the reasons why he would consider making a patient ‘involuntary’:

... the other [reason why involuntary committal procedures would be invoked] is expressing your general unhappiness or unwillingness to remain in hospital. I tend to listen to my patients and if they tell me that they are unhappy, I take it that they are not consenting.⁶⁸

Such an interpretation clearly eviscerates the doctrine of consent rendering it operative only in circumstances where the subject agrees with a proposed treatment; ‘consent’ becomes a thing of purely cosmetic value, always subject to the exercise of coercion albeit sometimes masked by a velvet glove.

⁶⁵ Annas (1999) p.1409: “*The Supreme Judicial Court took the case directly, and all seven justices, in a unanimous decision, vacated the judgment and remanded the case to the Superior Court for a new trial.*” The Massachusetts Supreme Judicial Court subsequently reaffirmed the existing law (*supra*).

⁶⁶ MHC (2008c), p.61.

⁶⁷ Dr. Harry Kennedy is the Clinical Director of the Central Mental Hospital.

In that Dr. Kennedy did not appear to see himself as enunciating anything other than the general understanding of his professional colleagues, this shows a clear divergence between current psychiatric practice and the law which is set out by O’Neill (2005); see Appendix H for a fuller discussion.

⁶⁸ Browne (2005b); see Appendix H for a fuller discussion.

A.4.3.2.2: The Superior Courts

The Irish Supreme Court in its interpretation of mental health legislation, not only does not “*want a return to the practice of old-time medical paternalism*”⁶⁹ it, apparently, has never left it. For example, the Irish Supreme Court has displayed an intolerance towards arguments which are based either on the breach of the ‘technicalities’ of the Mental Health legislation or which seek to give precedence to the liberty of the individual: “*We do not feel called upon by authority or otherwise to apply to this case the sort of reasoning that would be applied if it were a criminal detention ...*”⁷⁰

This, and similar, cases were discussed more fully in the Introduction to this dissertation where the point was also made that the willingness of the Irish courts to conflate issues of dangerousness and paternalism, severely compromises even the pretence of intellectual rigor in the analysis of the legal principles that should govern coercive psychiatric interventions.⁷¹

Section B: Coercive psychiatric interventions from the perspective of third party observers

A coercive psychiatric intervention has in itself – and distinguishable from the effects of psychiatric treatment – effects on the life of a subject such as, for example, the fostering of a belief that such individuals may lack responsibility for their actions or that they are not amenable to rational discussion and persuasion or that they are dangerous. Such effects constitute a continuing stigma and may encroach on the subject’s

Personhood_{ETH}, Personhood_{LAW} and Personhood_{SOC}; they will be discussed in *Subsection B.1.*

The invasive effects of the coercive administration of some psychoactive medications – such as antipsychotics – on the psyche of the subject has been mentioned in earlier chapters; they will be discussed in *Subsection B.2* from the perspective of third party observers.

Some preliminary remarks

The accounts given in this and the following section (Section C) have been culled from various sources and offer a glimpse into a world of experiences which is often not only unaddressed, but unacknowledged. The aim of these sections is to show how – in particular cases – a coercive psychiatric intervention or a coercive administration of

⁶⁹ Annas (2000) (*supra*).

⁷⁰ *E.H. v St. Vincent's Hospital & ors* (2009) citing *Cudden v The Clinical Director of St. Brigid's Hospital* (2009).

⁷¹ See Chapter 6.

antipsychotics may have catastrophic effects on the personhood of a subject. It may be that such consequences can be justified, but that is a secondary question to be addressed only when the full extent of the consequences is made clear. It may also be that these accounts are not representative but any objection on that score can be countered by an appeal to the Precautionary Principle which implies that once such experiences have been shown to occur they must not be assumed to be unrepresentative until they have been proved to be so.

B.1: Some effects of coercive psychiatric intervention

The Rosenhan experiment⁷² involved the admission of pseudopatients to psychiatric hospitals in an attempt to discover whether “*the sane can be distinguished from the insane.*”⁷³ The study concluded that:

Despite their public ‘show’ of sanity, the pseudopatients were never detected. Admitted, except in one case, with a diagnosis of schizophrenia, each was discharged with a diagnosis of schizophrenia “*in remission.*” ... It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals.⁷⁴

The implications of the study in relation to the reliability of psychiatric diagnosis have been discussed in Chapter 4; the aspect that is of interest in the present context is the “*depersonalization and invisibility*”⁷⁵ that was experienced by the pseudopatients – an experience which, Rosenhan argues, is unknown to most psychiatrists.⁷⁶ Rosenhan

⁷² Rosenhan (1973) (*supra*).

⁷³ *Ibid*, p.250.

⁷⁴ Rosenhan (1973), p.257.

See also Deane (1961) who recounts how the effects of hospitalisation may mimic those of mental illness. Deane who was a member of staff of a mental hospital, spent a week in one of the wards acting as if he were a patient; he noted that:

I took on in mild form some of the symptomatology of certain of the patients ... suggests that some of the symptomatology of mental patients may be due to the effects of hospitalization and not to the fact of mental illness *per se*. (p.68)

⁷⁵ Rosenhan (1973) p.257.

Though psychoactive medications were given to the pseudopatients, they avoided swallowing them and thus cannot describe their effects. Concerning the medication, Rosenhan comments (p. 257):

All told, the pseudopatients were administered nearly 2100 pills, including *Elavil*, *Stelazine*, *Compazine*, and *Thorazine*, to name but a few. (That such a variety of medications should have been administered to patients presenting identical symptoms is itself worthy of note.) Only two were swallowed.

⁷⁶ Rosenhan (1973), p.251:

Too few psychiatrists and psychologists, even those who have worked in such hospitals, know what the experience is like. They rarely talk about it with former patients, perhaps because they distrust information coming from the previously insane.

attempted to quantify the extent of the depersonalisation⁷⁷ but, he argued, that even the persuasiveness of such data does not do justice to the level of depersonalisation that had been encountered:

- Powerlessness was evident everywhere. The patient is deprived of many of his legal rights by dint of his psychiatric commitment. He is shorn of credibility by virtue of his psychiatric label.⁷⁸
- Neither anecdotal nor “hard” data can convey the overwhelming sense of powerlessness which invades the individual as he is continually exposed to the depersonalization of the psychiatric hospital. At times, depersonalization reached such proportions that pseudopatients had the sense that they were invisible, or at least unworthy of account.⁷⁹
- The mentally ill are society’s lepers.⁸⁰

Rosenhan suggests the term “*mortification*” as being an appropriate description of this process.⁸¹

The Rosenhan study dates from 1973 and it may well be imagined that we now live in more enlightened times and that such attitudes could no longer persist. A report commissioned by the Irish Mental Health Commission [MHC (2009)] gives scant reason for optimism. The Inquiry arose out of concern at the high level of injuries being sustained by patients in Tipperary mental hospitals and suggestions that the injuries might have been the result of assaults by members of the nursing staff.⁸²

The most cogent evidence in the disparity between the rights of patients and those of staff members is provided by the stance adopted in the report itself which – despite the

⁷⁷ He contrasted how psychiatric staff responded to attempts by pseudopatients to initiate contact, with the results of similar experiments including one at Stanford University campus (where staff were alleged to be so busy that they had no time to talk to students). The results are shown in the following table (Abstracted from Rosenhan (1973) Table 1, p.255):

	<i>Psychiatrists</i>	<i>Nursing staff</i>	<i>Stanford University campus</i>
<i>Ignored questions, moved on with head averted</i>	71%	88%	0%
<i>Made eye contact</i>	21%	10%	100%*

* Rosenhan’s table gives a figure of 0% but the correct figure is 100% as is made clear by the accompanying commentary [“.. all respondents not only maintained eye contact, but stopped to talk”].

Table 7-2: Response to attempts by pseudopatients to initiate staff contact

⁷⁸ *Ibid.*, p.256.

⁷⁹ *Ibid.*; he continues:

Reactions to such depersonalization among pseudopatients were intense. Although they had come to the hospital as participant observers and were fully aware that they did not “belong,” they nevertheless found themselves caught up in and fighting the process of depersonalization. ... – all of this as a way of becoming a person in an impersonal environment.

⁸⁰ *Ibid.*, p.254.

⁸¹ *Ibid.*, p.257: “Goffman calls the process of socialization to such institutions ‘mortification’ – an apt metaphor that includes the processes of depersonalization that have been described here.”

See also Goffman (1968), p.24 *et seq.*

⁸² *Ibid.*, p.133: there was a “... strong possibility of non-accidental injury. ... The possibility of informing the Gardai was considered.”

manifold deficiencies in professional practice and standards,⁸³ (including inappropriate use of sedation,⁸⁴ wrongful detention⁸⁵ and mistreatment⁸⁶ of patients) – declined to assign individual blame to any of the professionals involved.⁸⁷ The Inquiry’s obligation to vindicate the rights of the patients all but vanished⁸⁸ in the face of, what it considered to be, its obligation of fairness to “*individuals and parties to the inquiry*” by which it apparently meant the various professionals under scrutiny.⁸⁹

The Rosenhan experiment and the MHC (2009) report offered broad perspectives on the process of depersonalisation; other commentators have taken more specific aspects of depersonalisation as their point of focus. It is convenient to discuss some of the effects separately; the most prominent (and the one which has received most academic attention) is ‘*stigma*’ which will be discussed in B.1.1; other effects will be discussed in B.1.2.

B.1.1: Stigma

Although definitions of stigma differ in the breadth of experiences they describe, “... *there is agreement on what ‘stigma’ is (a mark of disgrace or discredit that sets a person aside from others).*”⁹⁰ In the present context ‘*stigma*’ refers to the negative

⁸³ MHC (2009), p.71; see also Chapter 5.

⁸⁴ *Ibid.*, p.128; see also Chapter 5.

⁸⁵ *Ibid.*, p.84; see also Chapter 5.

⁸⁶ For example, MHC (2009):

– “... residents ... on raised levels of observation, requiring them to wear night clothes during the day.” (p.32).

– “One resident told us that he had to go to bed at 4.30pm and often would like to stay up late.” (p.72).

– “In the high observation areas ... up to six unwell and disturbed residents were obliged to live in close proximity in a cramped, dirty and unpleasant area. ... residents’ personal space was restricted to the area on and around their bed.” (p.121).

⁸⁷ The report concluded that the inadequacy of record keeping entailed that staff on duty at the time of various incidents, could not be easily identified and “... identification of members of staff might still put them in an invidious position.” [*Ibid.*, p.143.]

⁸⁸ The inquiry saw its primary purpose as “... to identify possible improvements to the care and treatment ... Apportioning blame is not the primary purpose. The Inquiry Team is not a disciplinary body.” [*Ibid.*, p.193.]

The report also details the many interest groups (e.g. the Local Health Manager, HSE South, Psychiatric Nurses’ Association, consultant psychiatrists) that sought, with the assistance of their lawyers, amendments to the draft report. [*Ibid.*, p.15.]

⁸⁹ The report concluded that the procedure that it finally adopted was “... fairest to individuals and to the parties to the inquiry and this was in keeping with the principles of natural justice.” [*Ibid.*]

⁹⁰ Byrne (2001), p.281.

See also Thornicroft (2006), p.170:

This term [*i.e.* ‘*stigma*’] (plural *stigmata*) was originally used to refer to an indelible dot left on the skin after stinging with a sharp instrument, sometimes used to identify vagabonds or slaves. The resulting mark led to the metaphorical use of ‘*stigma*’ to refer to stained or soiled individuals who in some way morally diminished. In modern times *stigma* has come to mean any attribute, trait or disorder that marks an individual as being unacceptably different from the ‘normal’ people with whom he or she routinely interacts, and that elicits some form of community sanction.

attitudes towards those who have been the recipient of a diagnosis of psychiatric illness;⁹¹ such stigmatisation – especially for those diagnosed with schizophrenia - seriously affects their lives by its effects, for example on job prospects and relationships.⁹²

The manifestation of stigmatising attitudes, by psychiatrists is discussed in *B.1.1.1*; its manifestations in the wider society, in *B.1.1.2*.

B.1.1.1: Stigma attributable to psychiatrists

In 1998, the Royal College of Psychiatrists launched a 5-year campaign in an attempt to lessen the stigma associated with psychiatric illness. In conjunction with this campaign, Kingdon (2004) examined the attitudes of psychiatrists towards their patients; he concluded that:

In terms of attitudes, psychiatrists do seem to generally hold non-stigmatising views in comparison with the general population. Individually and collectively, they are well placed to take leading roles in combating stigmatisation.⁹³

Kingdon's (2004) study was by way of a survey which asked questions such as "*Can most women who were once patients in a mental hospital be trusted as babysitters?*"

The validity of such self-reports is open to question⁹⁴ especially when the same survey found that nearly half of all the psychiatrists surveyed considered the misdiagnosis of schizophrenia in black people by (presumably) other psychiatrists to be "*common*".⁹⁵ A companion study of the stigmatising attitudes of non-psychiatric doctors was considerably less sanguine.⁹⁶

A number of studies exist which have utilised a more robust methodology than that employed by Kingdon (2004) and whose findings contradict his; such studies have found, for example, that:

⁹¹ Byrne (2001) notes (p. 282) that the classification of Alzheimer's dementia as a 'psychiatric' illness has "... brought its own additional stigma."

⁹² Kingdon (2004), p.401.

⁹³ *Ibid.*

⁹⁴ See, for example, Dovidio & Fazio (1991) (p.223) who cite research to the effect that self-reports on attitudes concerning socially sensitive issues, are considerably less reliable than results obtained by more indirect methods.

⁹⁵ Kingdon (2004), p.402; see also p.405: "*Inevitably, they reflect psychiatrists' own perception of their attitudes and may well be distorted in terms of what they perceive to be professionally desirable responses.*"

See Chapter 4, *supra*, for a fuller discussion.

⁹⁶ Mukherjee (2002) found that:

More than 50% felt that people with any of these conditions [GR: *i.e.* schizophrenia, drug addiction and alcohol addiction] were dangerous and unpredictable. ... There was also the feeling among more than 50% of the respondents that people with depression, dementia and schizophrenia were difficult to talk to. (p.179).

Over half of those surveyed believed that those diagnosed with schizophrenia would "*never recover.*" (p.180: Table 4).

- (i) psychiatrists manifest stigmatising attitudes towards their patients to as great, if not a greater, degree than do the general population [B.1.1.1.1];
- (ii) the psychiatric intervention itself may be the cause of stigma and that some psychiatrists are cavalier about such a possibility [B.1.1.1.2].

B.1.1.1.1: Stigmatising attitudes of psychiatrists

Some general results are first discussed [B.1.1.1.1.1] and then some more specific studies: Nordt (2006) [B.1.1.1.1.2] and Clarke & Rowe (2006) [B.1.1.1.1.3].

B.1.1.1.1.1: Some general results

Thornicroft (2006) reports that:

... many mentally ill people do not speak highly of mental health staff, ... The experience of people with mental illness is that they often feel patronized, punished or humiliated by such contact. Indeed service users often rate mental health staff as one of the groups which most stigmatises mentally ill people.⁹⁷

If anything, service users report that some family physicians/general practitioners are even more often stigmatising than psychiatrists in responding unsympathetically to people with mental illnesses.⁹⁸

Thornicroft uses the term “*dehumanisation*” to describe such experiences:

The core issues that occur time and again in service users accounts are being spoken to as if they were children, being excluded from important decisions and staff assuming the lack of capacity to be responsible for their own lives. ... and feeling that behind many encounters with psychiatric staff is the usually unspoken threat of coercive treatment.⁹⁹

An editorial¹⁰⁰ in the *British Medical Journal* echoes these views:

Certain themes and sources of stigmatisation, often neglected, emerge as worthwhile targets in most places. Among them are the behaviour of medical professionals (psychiatrists in particular) ... How should we convince others ... if we do not show the way by our own behaviour?¹⁰¹

Summerfield (2001), noting that the anti-stigma campaign launched by the Royal College of Psychiatrists attributes such stigma almost wholly to non-psychiatrists, comments:

⁹⁷ Thornicroft (2006), p.87. [References omitted]

⁹⁸ *Ibid.*, p.94.

⁹⁹ *Ibid.*, p.95.

¹⁰⁰ Sartorius (2002); the editorial has the subheading: “*Begins with behaviour and attitudes of medical professionals, especially psychiatrists.*”

¹⁰¹ *Ibid.*, p.1470-1.

A patient survey reinforces these concerns; it found that:

44% of people who had experienced mental distress said that they had experienced discrimination from GPs. The most frequently expressed form of discrimination was that physical illness was not taken seriously or was attributed to mental distress or psychosomatic sources. As one person reported: “*Everything, including physical problems (are) attributed to mental health problems.*” [Mental Health Foundation (2000), pp. 9-10.]

This rather recalls the way that people once regarded '*institutionalization*' as a psychological attribute of longstay psychiatric inpatients, ignoring the contribution of psychiatric practice itself ... I point to some facets of the sociology of stigma that highlight psychiatry as something more than an innocent bystander.¹⁰²

Having given examples (discussed *infra*) of psychiatric intervention which, without conferring any compensating benefit, cause such stigma, Summerfield (2001) asks:

Thus psychiatry may have little specific to offer to many of those it has nonetheless deemed sick in one way or another. The intervention may be stigmatizing in its own right. Is the Royal College campaign thinking about this?¹⁰³

McKay (2000) cites a study which found that "... *health professionals may have even more negative attitudes to mental disorder than the general public.*"¹⁰⁴ and suggests that:

A public campaign to combat stigma is undoubtedly important, but perhaps we should be prepared to examine our own beliefs about serious mental illness as a prelude to changing attitudes in society at large.¹⁰⁵

Support for McKay's (2000) observation can be found from two studies – one Swiss [Nordt (2006)] and one English [Clarke & Rowe (2006)] – which will be discussed separately because the methodology adopted by these studies permits a revealing light to be shed, not only on the prevalence of stigmatising attitudes amongst psychiatrists, but on the prevalence of psychiatric misdiagnosis (a theme discussed in Chapter 4 *supra*).

B.1.1.1.1.2: Nordt (2006)

The study was based on a sample of 1,073 mental health professionals¹⁰⁶ and 1,737 members of the public. The study sought to determine both the level of knowledge of, and the attitudes towards, mental illness.

To test knowledge, the respondents were asked whether the person depicted in a short vignette was suffering from a mental illness; the vignettes were of two types: the first fulfilling relevant DSM criteria; the second – the '*non-case*' – described persons in a "... *changing life situation without any psychiatric symptom.*"¹⁰⁷ Respondents were

¹⁰² *Op. cit.*, p.148.

¹⁰³ *Ibid.*, p.149.

¹⁰⁴ McKay (2000), p.468.

See Thornicroft (2006), p.93: "*Professionals were generally more pessimistic about the chances of recovery than the general public, and psychiatrists were even less optimistic than nurses.*"

See also the Stigma Shout (2008) survey of over 3000 UK 'service users' as to how best to combat stigma; it placed GPs and psychiatrists in the top 10 of the 25 groups to be targeted.

¹⁰⁵ McKay (2000), p.468.

¹⁰⁶ Drawn from all 32 of the psychiatric institutions in the Swiss-German provinces of Switzerland.

¹⁰⁷ Nordt (2006), p.710.

asked "... to indicate whether the person described suffers from a 'mental illness' or 'reacts in a normal way to a difficult life situation'."108

To test attitudes, questions were asked on "stereotypes, restrictions and social distance towards people with mental illness."109 To test stereotypes, participants rated the extent by which people with mental illness differed from the general public with respect to being, for example, " 'dangerous', 'unpredictable', 'stupid,' 'bedraggled,' 'abnormal,' 'unreliable,' 'weird,' ... "110

To assess the acceptability of restricting the individual rights of people who are mentally ill, respondents were asked:

- "Should a woman who had suffered severely from a mental illness have an abortion in the case of a pregnancy?";
- "Do you approve of the right to vote and to run for office for somebody who had suffered severely from a mental illness?";
- "Should somebody who is severely mentally ill have her/his driver's license revoked?"; and
- "Should somebody be admitted to a psychiatric hospital even against his/her will and if needed retained, or should a person under no circumstances be compulsorily admitted to a psychiatric hospital?"111

To test social distance, the 'Social Distance Scale' was used:

... [which] consists of 7 questions assessing the willingness to interact with the person described in various social situations, eg, 'Would you like having your children marry someone like Beat?'

The study concluded that:

- Social distance: Psychiatrists manifested 12.5% more social distance towards those diagnosed with schizophrenia than did the general public;112 on which Nordt (2006) commented: "Social distance is one of the most significant components of stigmatization."113
- Restrictions: Whereas mental health professionals accepted restrictions (other than coercion) toward people with mental illness 3 times less often than the public;114 98.5% of psychiatrists agreed with compulsory admission as against 67.5% of the general public.115

108 *Ibid.*

109 *Ibid.*, p.709.

110 *Ibid.*, p.710.

111 *Ibid.*

112 *Ibid.*, p.713, Table 4.

113 *Ibid.*, p.713.

114 *Ibid.*, p.712, Table 2.

115 *Ibid.*

- Stereotypes: “Psychiatrists had more negative stereotypes than any of the other groups.”¹¹⁶
- Accuracy of categorisation of vignette: The results of the study can be viewed from two perspectives: the recognition of the mentally ill (*as per* DSM criteria) as ‘mentally ill’; and the recognition of the non-mentally ill (*as per* DSM criteria) as not being mentally ill.

Recognition of the mentally ill:

More than 94% of participants in each professional group recognized the person in the schizophrenia vignette as having a mental illness, whereas every fourth person in the public sample considered the depiction to be a normal reaction to a difficult life situation.¹¹⁷

Recognition of the non-mentally ill:

The person in the non-case vignette ... was seen predominantly as experiencing a “*crisis*,” yet one-fourth of the psychiatrists and psychologists considered this person “*mentally ill*.”¹¹⁸

Such results clearly point to the possibility of a high level of psychiatric misdiagnosis leading to coercive intervention; it lends impressive support to the conclusion drawn earlier¹¹⁹ that the rate of coercive interventions precipitated by a misdiagnosis (and which would not have occurred in the absence of that misdiagnosis)¹²⁰ was of the order of 25% of all such interventions.

Nordt (2006) concludes:

If one is sensitive to questions of stigma and labeling, one might be reluctant to define a person as “*mentally ill*.” But if this were the case, why did every fourth or fifth professional assign this stigmatizing term to the “*normal person*” in the non-case description?¹²¹

But before mental health professionals can inform and teach the general public about mental illness and thus help to reduce its stigma, they should carefully examine their own attitudes.¹²²

B.1.1.1.1.3: Clarke & Rowe (2006)

There is a widespread perception amongst the general public¹²³ that mental illness – particularly schizophrenia – is associated with a heightened propensity to violence;

¹¹⁶ *Ibid.*, p.711; Table 1 gives 3.25% as the measure of the excess.

¹¹⁷ *Ibid.*

¹¹⁸ *Ibid.*, p.714.

¹¹⁹ See Chapter 4 *supra*.

¹²⁰ *I.e.* radical misdiagnoses.

¹²¹ *Op. cit.*, p.712.

¹²² *Ibid.*, p.711.

¹²³ See Chapter 6 *supra*.

Clarke & Rowe (2006) sought to determine whether psychiatrists shared the same stereotype; the authors reasoned that:

If such a prejudice were clinically important, psychiatrists would be more likely to diagnose schizophrenia in a patient who had a history of being violent than in one without a violent history.¹²⁴

[*N.B.*: It is important to note that the risk of violence is not a diagnostic criterion for schizophrenia.]¹²⁵

The method adopted was to devise a clinical vignette “*with a diagnostically non-specific psychotic mental illness.*”¹²⁶ which was then varied to include :

- (1-nv): a non-violent domestic scenario [“... *increasingly argumentative with his girlfriend*”];
- (1-v): a violent domestic scenario [“... *and has pushed her and hit her on a few occasions*”];
- (2-nv): a non-violent social scenario [“... *he has begun to take a circuitous route ... to avoid them*”];
- (2-v): a violent social scenario [“... *he has begun to carry a knife to protect himself*”].

One vignette was mailed to each of the 2000 consultant psychiatrists who were asked to give a preferred diagnosis.¹²⁷

An analysis of the results showed that the introduction of the possibility of violence to scenario 1 (*i.e.* 1-nv to 1-v) increased the likelihood of diagnosis of schizophrenia by 47.8%; and in scenario 2 (*i.e.* 2-nv to 2-v), by 25.3%.¹²⁸ The data was also analysed by the gender of the diagnosing psychiatrist and it was found that male psychiatrists were 27.8% more likely to diagnose schizophrenia than were female psychiatrists who were working on identical information.¹²⁹

¹²⁴ Clarke & Rowe (2006), p.254.

¹²⁵ *Ibid.*, p.256:

However, neither *ICD-10* (World Health Organization, 1992) nor *DSM-IV* (American Psychiatric Association, 1994) include risk of violence as a diagnostic criterion or make any statements about the relative risk of violence according to diagnosis.

¹²⁶ *Ibid.*, p.254:

A 27-year-old man presents as an emergency. He has never seen a psychiatrist before but his girlfriend believes that he was briefly given some tablets for his nerves by his general practitioner about 5 years ago. He has been well since. Over recent weeks his girlfriend has become increasingly concerned about his health. His sleep has been disturbed at night and he has begun to make odd comments. For example, he has said that he has large sums of money in an offshore bank account and that people are out to get him because of this. ... She cannot identify any precipitant for these changes but did comment that he was previously putting in a lot of hours at work.

¹²⁷ *Ibid.*

¹²⁸ *Ibid.*, p.255; extracted from Tables 3 and 4.

¹²⁹ *Ibid.*, p.255; extracted from Table 2.

Such results again suggest a high level of radical misdiagnosis and adds further support to the conclusion drawn earlier.

Clarke & Rowe (2006) concluded that:

Psychiatric diagnosis, being syndrome¹³⁰ based and lacking objective investigations which confirm or exclude diagnoses, is particularly vulnerable to prejudice and bias.¹³¹

B.1.1.1.2: The psychiatric intervention as a cause of stigma¹³²

Sartorius (2002), in an editorial in the *British Medical Journal*, notes that: “A most obvious source of stigmatisation is the careless use of diagnostic labels.”¹³³

Thornicroft (2006) notes that: “... there has been an active debate on whether labelling ‘caused’ mental illness.”¹³⁴ and comments: “It is widely believed that psychiatrists use diagnostic labels in a cavalier way.”¹³⁵

The stigma caused by psychiatric intervention may extend beyond inappropriate diagnostic labelling to the stigmatising consequences of pharmacological treatments themselves (especially antipsychotics):

Iatrogenic stigmatisation unfortunately does not stop at labelling. Treatment of symptoms of mental illness may produce side effects ... which will mark the person as having a mental illness more than the original symptoms of illness did.¹³⁶

Summerfield (2001) also highlights how some psychiatric interventions can be deeply stigmatising without conferring any compensating benefit:

Those whom psychiatrists first label personality disorder and then deem untreatable – a common circumstance – are more stigmatised than if they had been left alone. With antisocial behaviour, can the knowledge that a psychiatrist has become involved with a case harden rather than dissipate negative attitudes? When mental illness seems to be absent, the entry of the psychiatrist might be perceived by the patient, the family, the legal system and potential employers as delivering a judgment on that person's whole history, prospects and indeed basic worth as a citizen.¹³⁷

¹³⁰ By ‘syndrome’ is meant a condition whose diagnostic criteria may be randomly clustered and thus be without any inherent connection.

¹³¹ *Ibid.*, p.256.

¹³² Thornicroft (2006) notes that “... there has been an active debate on whether labelling ‘caused’ mental illness.” (p.157)

¹³³ *Op. cit.*, p.1470.

¹³⁴ *Op. cit.*, p.157.

¹³⁵ *Ibid.*, p.92.

¹³⁶ Sartorius (2002), p.1470.

See also Chaplin (2000), p.467:

People with schizophrenia may not appear any different to the general public. However, side-effects such as drooling and tardive dyskinesia immediately point out an individual as being socially undesirable.

¹³⁷ Summerfield (2001), p.148.

This view of stigma as being sufficient to attack an individual's "basic worth as a citizen" goes to the heart of the thesis being advanced in this chapter, namely, that a coercive psychiatric intervention may be such as to diminish or destroy an individual's Personhood_{SOC}. Such an attack on an individual's "basic worth as a citizen" is also facilitated by psychiatry's reliance on speculative theories as to the biological or genetic causation of psychiatric disorders:

.... propagation of the medical model will perpetuate stigma: information on genes and 'chemical imbalances' implies that those with mental illness have no control over or responsibility for their actions.¹³⁸

The discussion in this subsection [B.1.1.1] concerned the manifestation of stigmatising attitudes by psychiatrists and may be summarised in the conclusion:

*Studies designed to assess the presence amongst psychiatrists of stigmatising and stereotypical attitudes towards their patients have found such attitudes to be as (if not more) prevalent as amongst the general public; the presence of such attitudes indicate a substantial (c. 25%) possibility of misdiagnosis, especially of schizophrenia, and thus likely to precipitate inappropriate coercive intervention. Because of the absence of adequate countervailing forces (e.g. rigorous chemical or biological tests or independent third-party or legal scrutiny) such misdiagnosis is especially resistant to correction.*¹³⁹

¹³⁸ Byrne (2001) (*supra*) p.281 citing Read & Law (1999); Byrne (2001) finds it " ... surprising that psychiatric textbooks omit stigma as either subject or indexed item." (p.281).

See also Watters (2010) who reports on studies which found that the biochemical model of psychiatric disease is more stigmatising than the psychosocial one:

The problem, it appears, is that the biomedical narrative about an illness like schizophrenia carries with it the subtle assumption that a brain made ill through biomedical or genetic abnormalities is more thoroughly broken and permanently abnormal than one made ill through life events.

"Viewing those with mental disorders as diseased sets them apart and may lead to our perceiving them as physically distinct. Biochemical aberrations make them almost a different species."

... It turns out that those who adopted biomedical/genetic beliefs about mental disorders were the same people who wanted less contact with the mentally ill and thought of them as more dangerous and unpredictable. This unfortunate relationship has popped up in numerous studies around the world.

[Watters, E. (2010). 'The Americanization of Mental Illness.' *The New York Times*. 8 January.]

See also Chamberlin (2006), p.xii:

The mental health industry has been notably successful in convincing the public that people with psychiatric diagnoses are biologically distinguishable from so-called 'normal' people, yet there exists no blood test, x-ray, or any other biologically based marker that serves a diagnostic purpose. Psychiatric diagnosis continues to be, as it has been throughout its history, a matter of clinical impression in which a person's own protestations of not being mentally ill are taken as one of the strongest pieces of evidence that he or she in fact is. [Emphasis in original]

Thornicroft (2006) (p. 212-3) notes that 'denial' has been studied far more in relation to cancer - where it has been found to have "some positive effects" - than in relation to psychiatry where:

Little attention has been paid to whether people with mental illness may have valid reasons to reject such diagnoses ... On the face of it, therefore, there seem to be strong reasons why a person offered a diagnosis of mental illness may choose not to accept it, especially if this will mean making important sacrifices.

¹³⁹ See, for example, Witztum (1995a) and Witztum (1995b), discussed in Chapter 4 (*supra*).

B.1.1.2: Stigma as manifested by non-psychiatrists

After some introductory remarks [*B.1.1.2.1*], some specific studies are individually examined:

- Crisp (2000) [*B.1.1.2.2*]
- Byrne (2000) [*B.1.1.2.3*]
- Crisp (2001) [*B.1.1.2.4*]
- Haghghat (2001) [*B.1.1.2.5*]
- Thornicroft (2009) – the ‘INDIGO’ study – [*B.1.1.2.6*]

B.1.1.2.1: Introductory remarks

Thornicroft – who is a consultant psychiatrist and Head of Health Service Research at the Institute of Psychiatry – is of the opinion that “... *once a person has been designated as a ‘mental patient’ then this is a largely indelible label.*”¹⁴⁰ Moreover such a label can, to the individual concerned, become all-encompassing – “*the defining aspect of their core identity.*”¹⁴¹

The permanent and pervasive nature of psychiatric labelling – and the consequences entailed by such labelling – is well illustrated in an account¹⁴² given by Richard Bentall¹⁴³ of the experience of a patient of his (Andrew) who had been badly injured in a traffic accident at 15; who had suffered flashbacks and had been subsequently diagnosed as suffering from Post Traumatic Stress Disorder (PTSD). He had joined the British Army and had been posted to Northern Ireland where, being of Catholic Irish background, he had been badly bullied by his fellow soldiers. He complained of this and had eventually been retired on psychiatric grounds.

A prolonged dispute ensued over his pension entitlements which were dependent on his diagnosis.¹⁴⁴ Andrew consulted Bentall and – though acknowledging that he was unwell – disputed the diagnosis of paranoid schizophrenia. Bentall continues:

Shortly after Andrew visited me, his grandmother died. At her funeral he became very upset. Fearing that he might be suffering a relapse one of his brothers (with whom he had a very bad relationship) decided to alert his doctor, who in turn

¹⁴⁰ Thornicroft (2006), p.155.

¹⁴¹ *Ibid.*, p.161; he continues:

This progression from seeing oneself as having a particular condition (along with many other characteristics and attributes), to being essentially identified by the disorder is a crucial step as these labels confer a lower social value on people to whom they stick, both in that person’s own eyes, and in the estimation of others. [Emphasis in original]

¹⁴² Bentall (2009).

¹⁴³ Richard Bentall is Professor of Clinical Psychology at Manchester University.

¹⁴⁴ If the diagnosis was PTSD, exacerbated by bullying, the army would have some liability; but if his complaints of bullying were interpreted as a persecutory delusion meriting a diagnosis of schizophrenia – a diagnosis made by an army psychiatrist and agreed with by a psychiatrist to whom Andrew had been referred by his family GP – the army would not have been liable.

called out the psychiatric team. Knowing that he was prone to anger, [they] chose to turn up at Andrew's home accompanied by six policemen. Andrew was told that he had no option but to accompany the policemen to a local psychiatric ward where he would be subjected to a psychiatric examination.

Many ordinary people confronted in this way would be furious. However, to Andrew's credit, he realised that any attempt to resist the policemen would only have lead to more trouble.¹⁴⁵

Some days later Bentall visited Andrew in the hospital where he had been detained against his will:

He was sitting quietly, wearing a suit, and reading a novel. (I later learned from clinical notes that the fact that he was well dressed was seen as evidence that he was 'grandiose'.) Although affronted by what had happened to him, he seemed completely rational. The junior doctor who was on duty could not give me a creditable explanation why he had been sectioned, but explained that he would remain under observation in the hospital over the Christmas period.¹⁴⁶

On leaving the ward Bentall spoke to one of the psychiatric nurses in the hope that he might glean details of any evidence of psychotic or irrational behaviour that might have justified his detention:

"He's excessively polite," the nurse explained darkly. ... *"... we're trying to work out whether his politeness is part of his normal personality or his illness."*¹⁴⁷

More formal studies have sought to analyse the concept of psychiatric stigma and to quantify both its extent and effects; some of these studies are now examined.

B.1.1.2.2: Crisp (2000)

Crisp (2000) – who noted that there had been no recent research on the prevalence of stigma in the UK¹⁴⁸ – sought to complete such a study which could then serve as a benchmark for the Royal College of Psychiatrists' 1998 anti-stigma campaign. The study consisted of a survey of the opinion of 2679 members of the public on eight topics relating to seven mental disorders; it concluded that:

Schizophrenia, alcoholism and drug addiction elicited the most negative opinions. Approximately 70% of respondents rated people with these conditions as dangerous to others and about 80% rated them as unpredictable.¹⁴⁹ ... There was a

¹⁴⁵ *Op. cit.*, p.111.

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.*, pp.111-2. The incident is reminiscent of how in the Rosenhan (1973) experiment (*supra*), psychiatric staff – looking myopically through the distorting lens of the psychiatric diagnosis – considered note writing to have pathological overtones and described it as *"writing behaviour."*

¹⁴⁸ Crisp (2000), p.4:

Many studies have shown that stigmatising attitudes towards people with mental illness are widespread ... and are commonly held ... but there has been no recent survey of a large representative sample of the population of Great Britain. [References omitted].

¹⁴⁹ Crisp (2000) adds (p.6) the somewhat bizarre comment: *"These opinions are accurate in the sense that a few people with these disorders behave at times in ways that are dangerous to others. However, the opinions are generalised too widely ..."*

common and widespread view that people with any of the disorders in question are hard to talk with ... and feel differently from others ... only schizophrenia and dementia were frequently rated as "will never recover", and for schizophrenia only one-half of respondents endorsed this response.¹⁵⁰

B.1.1.2.3: Byrne (2000)

Byrne (2000) because of the author's eminence,¹⁵¹ is of particular interest. Stigma, he writes, is "as a sign of disgrace or discredit, which sets a person apart from others." Its primary component is 'shame', it is pervasive¹⁵² and shows little signs of having lessened over recent years.¹⁵³

Byrne (2000) notes that "Some social scientists believed stigma was a function of labelling by psychiatrists"¹⁵⁴ but – relying on a single study from 1992 – he asserts that: "... this is not supported by the evidence."¹⁵⁵ and argues that "Mental illness stigma existed long before psychiatry,"¹⁵⁶ An argument which is difficult to sustain in the face of, for example:

- the high levels¹⁵⁷ of psychiatric misdiagnosis of schizophrenia and the "pervasive"¹⁵⁸ clinical pessimism surrounding its outcome.
- the observation that "In a unique move aimed to reduce social rejection, the name for schizophrenia has been changed in Japan."¹⁵⁹
- if one contrasts the situation of an individual who, being severely troubled and depressed, consults his priest, with a similar individual who consults a psychiatrist, the former will entail no stigma whilst the latter well may.¹⁶⁰

¹⁵⁰ *Ibid.*, p.5. It is of interest to note [in relation to the discussion on dangerousness in Chapter 6 (*supra*)] that drug addicts were regarded as being more dangerous than those with schizophrenia; alcoholics were only marginally less so:

	<i>Schizophrenia</i>	<i>Alcohol addiction</i>	<i>Drug addiction</i>
<i>Danger to others</i>	71%	65%	74%
<i>Unpredictable</i>	77%	71%	79%

Table 7-3: Public perceptions of dangerousness to others: schizophrenia vs. substance abuse

[Abstracted from Crisp (2000) p.5, Table 1.]

¹⁵¹ Byrne is a former chairman of the Public Education Committee of the Royal College of Psychiatrists in Ireland. [Byrne (2000), p.65].

¹⁵² Byrne (2000), p.66: "Discrimination occurs across every aspect of social and economic existence."

¹⁵³ *Ibid.*, p.65:

In two identical UK public opinion surveys, little change was recorded over 10 years, with over 80% endorsing the statement that "most people are embarrassed by mentally ill people", and about 30% agreeing "I am embarrassed by mentally ill persons".

¹⁵⁴ *Ibid.*, p.66.

¹⁵⁵ *Ibid.*

¹⁵⁶ *Ibid.*, p.65.

¹⁵⁷ Circa 25%: see Chapter 4 (*supra*) for a fuller discussion.

¹⁵⁸ van Zelst (2009) cites, as an example, Sawa & Snyder (2002): "Once the symptoms of schizophrenia occur (usually in young adulthood), they persist for the entire lifetime of the patient and are almost totally disabling."

¹⁵⁹ Thornicroft (2006), p.179; see also Takei (2005).

It is however in relation to his proposals to combat stigma that Byrne (2000) is most original:

... there is no word for prejudice against mental illness. One possible remedy to this would be the introduction of the term "*psychophobic*" to describe any individual who continues to hold prejudicial attitudes about mental illness regardless of rational contrary evidence. ... The challenge ... is to confront the stigmatiser with his or her irrational beliefs, in addition to enabling direct contact with "*one of them*".¹⁶¹

A proposal which – in view of the results of studies such as Nordt (2006) and Clarke & Rowe (2006) (*supra*) which found stigmatising attitudes to be widespread amongst psychiatrists – would doubtlessly be enthusiastically embraced by Byrne's professional colleagues!

B.1.1.2.4: Crisp (2001)

Crisp (2001), in an editorial in *The British Journal of Psychiatry*, writes that "... *schizophrenia, in recent years, has taken on this mantle to an ever greater extent, from the cancer and AIDS that Sontag was writing about.*"¹⁶²

He sees this stigmatisation as being due in part to the identification of the individual with the disorder with which they have been diagnosed (an identification facilitated by use of the 'biopsychosocial model') and "*Secondly, unlike many other stigmatised groups ... those with mental illnesses rarely fight their corner.*"¹⁶³

He notes that stigma appears to have been ever present in human history and, in an attempt to penetrate the reasons for this, he draws heavily on Haightat (2001) (*infra*) who seeks to uncover the source of psychiatric stigma in our "*evolutionary biological origins*":

¹⁶⁰ In that the very existence of a 'psychiatric history' may itself be stigmatising: see, for example, the events surrounding the withdrawal of US Vice Presidential candidate Thomas Eagleton in 1972 when the fact that he had received psychiatric treatment, became public.

See also the following examples:

Example 1: how psychiatric labels were used as very effective stigmatising mechanisms to undermine the testimony of Anita Hill in the US Senate hearings concerning the appointment of Clarence Thomas to the US Supreme Court. [Kutchins & Kirk (1997), p.1 *et seq.*]

Example 2: the controversy surrounding the questioning of Gordon Browne by a BBC reporter on whether the Prime Minister had taken antidepressants. [Kellaway, L. (2009). 'Marr controversy shows mental health a taboo workplace topic.' *The Irish Times*. 5 October.]

Example 3: how in relation to an assault on the Italian Prime Minister Berlusconi, the publication of the previous psychiatric history of the assailant was sufficient to remove the need for consideration of other possible motives such as the allegations of widespread corruption. [BBC News (2009). 'Italy's Berlusconi to stay in hospital after attack.' *BBC News*. 14 December [online], available: <http://news.bbc.co.uk/2/hi/europe/8411318.stm> [accessed: 26 May 2010].

¹⁶¹ Byrne (2000), p.67.

¹⁶² Crisp (2001), p.198 having quoted Susan Sontag: "... *diseases acquire meaning (by coming to stand for the deepest fears) ... It seems that societies need to have one illness, which becomes identified with evil, and attaches blame to its 'victims' ...* "

¹⁶³ *Ibid.*, p.197.

... we need to identify scapegoats and thereafter to condemn and avoid them. He then proposes that stigmatisations, whether they be of another race, fellow competitors or people with mental illnesses, are weapons in socio-economic competition.¹⁶⁴

Crisp (2001) asks:

Could our present-day attitude partly be fuelled by our ancient need to distance ourselves from 'poor reproductive bets' and those who are 'sexually unattractive'.¹⁶⁵

- a proposition which at first sight seems improbable in view of psychiatry's proven readiness to trammel 'excessive' female sexuality.¹⁶⁶

As to a solution?:

But Haightat's main hope comes through as being that humankind will grow up and adopt a more fraternal caring society, throwing off their biologically driven competitive nature and evolving along correct ideological lines.¹⁶⁷

Turning next to focus directly on Haightat (2001).

B.1.1.2.5: Haightat (2001)

Haightat (2001) having enumerated a number of causal factors of stigmatisation – 'constitutional',¹⁶⁸ psychological, economic and evolutionary – seeks to formulate a 'unitary' theory¹⁶⁹ which he hopes will permit the development of strategies to combat stigma.

The fruitfulness, or otherwise, of Haightat's (2001) digression into the fields of evolutionary biology can be judged from his concluding remarks which offer scant reason for optimism:¹⁷⁰

In ideologically favourable societies, opting for non-stigmatising behaviours could have reproductive value. ... What hinders a more equitable approach to other humans can only be the vestiges, in our genome, of our animal evolutionary

¹⁶⁴ *Ibid.*

¹⁶⁵ *Ibid.*

¹⁶⁶ Such as, for example, the psychiatric diagnosis of nymphomania. See also the use of the diagnosis of erotomania to discredit the testimony of Anita Hill (*supra*) [Kutchins & Kirk (1997), p.2].

¹⁶⁷ Crisp (2001), p.198.

¹⁶⁸ By which he means factors constitutive of individuals which "... *interfere with the capacity for 'proper' social perception and information processing.*" [*Op. cit.*, p.207.]

¹⁶⁹ Haightat (2001) – which is entitled 'A unitary theory of stigmatisation.' – is summarised (p. 214):

Clinical Implications:

- The article presents a novel theory of stigmatisation that helps in understanding how patients are deployed as a commodity for other people's self-interest.
- It provides an account of several domains and in each is able to cover the relevant evidence and lead to new predictions.
- The unitary formulation has the double advantage of tenability and coverage and generates fruitful avenues of research.

¹⁷⁰ The poverty of the analysis is evident if one imagines it transposed to a discussion of stigmatising behaviour based on race.

heritage, whereas deployment of our newly acquired evolutionary autonomy can help us to develop cultures that promote destigmatisation.¹⁷¹

Though Haghghat (2001) casts his net wide in seeking the causes of stigmatisation, curiously neither he nor Crisp (2001) (*supra*) consider the possible role of psychiatry or psychiatrists both of which they implicitly cast in the role of ‘*innocent bystanders*’¹⁷² – a role which is difficult to reconcile with the results of studies such as Nordt (2006) (*supra*).

B.1.1.2.6: Thornicroft (2009) [the ‘INDIGO’ study]

In contrast to Crisp and Haghghat, Thornicroft (2009) [the ‘INDIGO’ study] provides a fruitful analysis of the phenomenon of stigma; it has been described as a “*landmark study*”¹⁷³ because of its scope and the novelty of its methodology.

The INDIGO study was a cross-sectional survey undertaken in 27 countries into the stigma associated with schizophrenia; and was “... *the first to assess systematically the experiences of people with schizophrenia globally.*”¹⁷⁴

Whereas most previous research on stigma and mental illness consisted of surveys of individuals as to their ‘attitudes’¹⁷⁵ *i.e.* the behaviour that individuals, presented with imaginary scenarios, anticipated evincing, Thornicroft (2009) sought to assess the behaviour that was actually manifested towards those known to have been diagnosed with schizophrenia;¹⁷⁶ the authors also developed a discrimination and stigma scale (DISC) and sought to assess both anticipated and actual discrimination.

Thornicroft (2009) notes that the stigma associated with mental illness has been called the “*ultimate stigma*”¹⁷⁷ with schizophrenia being “*one of the most stigmatised mental disorders.*”¹⁷⁸ The dearth of research into such stigma was such that “*we could not generate evidence-based hypotheses.*”¹⁷⁹

¹⁷¹ Haghghat (2001), p.213.

¹⁷² See Summerfield (2001) *supra*.

¹⁷³ Schulze (2009), p.362; who commented (p.363) that the INDIGO study:
... is breaking new ground, pointing to the kind of research we need to more fully understand stigma and discrimination. By investigating actual discrimination and self-stigma, the study brings together the structural and cognitive perspectives that have not previously been combined.

¹⁷⁴ Olabi (2009).

¹⁷⁵ Thornicroft (2009), p.408.

¹⁷⁶ *Ibid.*, p.413: “*Furthermore, we have deliberately focused on the direct reports of discrimination by people with mental illness for practical, ethical, and methodological reasons.*”

¹⁷⁷ See also Drury ‘Madness and Religion’ [in Drury (1996)]:

It is a common prejudice, and one hard to get free from, that a mental illness [is] a degradation of the total personality; that it renders the sufferer to some degree subhuman. Thus many people would feel that if Tolstoy really suffered from melancholia his challenge to our whole western way of life would be largely blunted and nullified. And if Joan of Arc was a schizophrenic she could not at the same time be a saint. But these are prejudices. (pp.135-6)

¹⁷⁸ Thornicroft (2009), p.409.

The study revealed “*high rates of discrimination on a global scale*”¹⁸⁰ and showed that ‘treatment duration’ and ‘the experience of coercive measures’ were predictive of discrimination¹⁸¹ and urged that less reliance be placed on compulsory treatment in future. In relation to this finding, Schulze (2009) comments:

In challenging stigma and discrimination, we must bear in mind that stigma can only be deployed in contexts of unequal power. In addition to protecting the civil rights of mentally ill people by antidiscrimination legislation, we should empower them to actively pursue their rights and challenge discrimination through education and protest.¹⁸²

B.1.2: Effects (other than stigma)

The inadequacy of the concept of stigma as a vehicle for describing the manifold discriminations that exist towards those who have been the subject of a diagnosis of psychiatric illness, is discussed in B.1.2.1; an illustrative list of some of these discriminations is given in B.1.2.2.

B.1.2.1: The inadequacy of the concept of stigma

Thornicroft (2006) maintains that it is not the self-reports of hypothetical *attitudes* towards those who have been the subject of a psychiatric diagnosis that is of importance, but the actual *behaviour* that is manifested towards them in real world situations.¹⁸³ Such a stance permits the adoption of a “*discrimination perspective*”:

... which requires us to focus not upon the ‘stigmatised’ but upon the ‘stigmatiser’. In sum, this means sharpening our sights upon human rights, upon injustice and upon discrimination as actually experienced by people with mental illness.¹⁸⁴

AIDS campaigns provide an example of the differing perspectives: a campaign focused on stigma becomes a plea for understanding and empathy but carries an aura of paternalism, whereas a campaign focused on discrimination becomes a demand for legally enforceable rights, and is embodied in a discourse of equality.

See also Ely (2005):

No one wants to think of themselves as having borderline personality disorder. ... It is the diagnosis of a pariah. ... Schizophrenia is a lifetime disorder characterized by “*downward drifts*” in social and professional function. It is not the word you wish to know yourself by.

Ely, E. (2005). ‘Meanwhile: The damned diagnosis and its tyranny.’ *The New York Times*. 26 July.

Elissa Ely is a psychiatrist.

¹⁷⁹ Thornicroft (2009), p.409.

¹⁸⁰ Schulze (2009), p.362.

¹⁸¹ Thornicroft (2009), p.414.

¹⁸² Schulze (2009), p.362.

¹⁸³ A stance which he utilises in Thornicroft (2009) (*supra*).

¹⁸⁴ Thornicroft (2006), p.191.

Chamberlin (who is a psychiatric ‘survivor’)¹⁸⁵ is even more emphatic than Thornicroft: “*The very word stigma is problematic, locating the problem as within the individual.*”¹⁸⁶ She suggests it be replaced by two words ‘*prejudice*’ and ‘*discrimination*’ and argues that:

To fight against stigma is to engage in a side skirmish rather than to take on the basic problem – that once a person is labelled ‘mentally ill’, he or she loses fundamental rights that everyone else takes for granted. In fact, most so-called anti-stigma campaigns are run by the very people and organizations that control and support the process of diagnosis and treatment. It is not, therefore, surprising that the subtext of many such campaigns is to encourage more people to enter treatment, ignoring the fact that once they do so, they, too, will find themselves lacking both basic rights and the status to protest against them.¹⁸⁷

The solution, she argues, is to focus “*not [on] lessening stigma*” but to ensure:

... that people labelled mentally ill retain their basic citizenship rights, particularly the right to challenge both the label and the treatment, and to retain basic control over one’s own life.¹⁸⁸

B.1.2.2: Some examples of discrimination

A list, culled from the literature, of some of the discriminations that may follow upon a psychiatric intervention is given below; it is not exhaustive and the accompanying text provides but the briefest comment or examples:

- employment [[B.1.2.2.1](#)];
- parenting abilities [[B.1.2.2.2](#)];
- poor healthcare [[B.1.2.2.3](#)];
- financial discrimination [[B.1.2.2.4](#)];
- social discrimination [[B.1.2.2.5](#)];
- diminution of rights [[B.1.2.2.6](#)];
- limitations on court access [[B.1.2.2.7](#)];
- limitations on voting rights [[B.1.2.2.8](#)];
- limitations on jury service [[B.1.2.2.9](#)];
- irrevocability of diagnosis [[B.1.2.2.10](#)];
- descriptions of discrimination [[B.1.2.2.11](#)].

¹⁸⁵ Chamberlin (2006), p.xi:

In the 1960s, I found out first-hand about the problems of prejudice, stigma and discrimination in the mental health system, by becoming a victim of involuntary commitment and forced treatment. That experience had the unintended consequence of giving my life purpose and direction, ...

¹⁸⁶ *Ibid.*, p.xii. [Emphasis in original].

¹⁸⁷ *Ibid.*, p.xi. [Emphasis in original].

¹⁸⁸ *Ibid.* [Emphasis in original]; see also:

Once a person has been defined as mentally ill, his or her own decision making ability is called into question, and therefore, his or her protests are often discredited or, even worse, labelled one more ‘symptom’ of his or her illness. [*Ibid.*]

B.1.2.2.1: Employment

Example 1: Thornicroft (2006) notes that “*It may come as a shock to see just how reluctant many employers are to take on people who have a diagnosis of mental illness.*”; he cites two US studies:

... which asked employers about who they would offer a retail sales job to. People with mental illness were seen to be just as undesirable as ex-convicts, or as ‘marginally adjusted individuals’. The only group whom the employers were even more reluctant to hire were people with active tuberculosis.¹⁸⁹

Example 2: On dismissal from employment, Thornicroft (2006) comments:

Yet the simple fact is that a diagnosis of mental illness is one of the most potent ways to remove a person from the workforce. ... The figures are formidable: in England one third of people with mental health problems say that they have been dismissed or forced to resign from their jobs ...¹⁹⁰

Thornicroft gives the example of a GP who was compulsorily admitted to hospital for bipolar disorder:

The problem starts once you go through the gates of a psychiatric hospital. Once you are labelled the notes start building up. Psychiatrists won’t retract anything, change the diagnosis, amend the notes. If you disagree with them, they say you lack insight. ... then I was sacked because it was written into my General Practice agreement that if a colleague is Sectioned ... they can be removed from the practice.¹⁹¹

B.1.2.2.2: Parenting abilities

Example 1: A survey undertaken by the National Disability Authority in Ireland found that 33% of those questioned believed that: “... *people with mental health difficulties should not be allowed to have children.*”¹⁹²

Example 2: Thornicroft (2006):

... there is little clear evidence to suggest that women diagnosed with a mental illness cannot parent. ... However, there is considerable evidence to show that women with severe mental illness lose custody of their children far more often than most parents. ... According to one Canadian report, parents with mental illness lose custody for reasons that would rarely be used for other parents.¹⁹³

¹⁸⁹ Thornicroft (2006), p.52.

¹⁹⁰ *Ibid.*, pp.50-1.

¹⁹¹ *Ibid.*, p.59.

¹⁹² Kelly, O. (2007). ‘Mentally ill “ought not have children” – survey.’ *The Irish Times*. 28 September. See also Tinsley (2009):

ONE-THIRD of people surveyed about their attitudes to mental health said they would not be able to accept someone with a mental health problem as a close friend. The same proportion also believed those suffering from mental health issues were below average intelligence. ...

Some 40 per cent of respondents said they would discriminate against someone with a history of mental illness on the grounds they were unreliable. [Emphasis in original]

Tinsley, O. (2009). ‘Attitudes survey reveals mental health stigma.’ *The Irish Times*. 9 October.

¹⁹³ Thornicroft (2006), p.38.

B.1.2.2.3: Poor healthcare

Example 1: Studies have shown that levels of misdiagnosis of physical illness as psychiatric illness and neglect of physical illness amongst those diagnosed with psychiatric illness, are significant.¹⁹⁴

Example 2: As has been noted in Chapter 5 (*supra*) and Appendix L, some psychoactive treatments (especially antipsychotics) can cause serious damage to the physical health of an individual.

Example 3: Thornicroft has noted that:

There is strong evidence that people with a diagnosis of mental illness, ... have less access to primary health care, and also receive inferior care for diabetes and heart attacks.¹⁹⁵

Thornicroft quotes the testimony of such an individual:

The worst I have come across is medical people. I suffer badly from stomach problems. ... But when I try to get help from my doctor, they say ‘*Oh it’s your depression*’, ... From the time doctors are aware of my mental problems, they talk at me, instead of to me, like I haven’t a mind of my own.¹⁹⁶

B.1.2.2.4: Financial discrimination

Example 1: A UK survey found that a 25% of those questioned said that they had been refused insurance or other financial services because of their psychiatric history.¹⁹⁷

B.1.2.2.5: Social discrimination

Example 1: The Irish Advocacy Network is a movement that fights for the rights of individuals who have experienced mental health problems. In seeking to organise a three-day conference, they contacted a number of Irish hotels to see if facilities were available:

They were astounded at several responses and suspect that hotel staff were reluctant to facilitate a conference whose audience for the first two days would consist of people with mental illness. One hotel quoted an extraordinary price of

¹⁹⁴ See Chapter 4 (*supra*) were, for example, Bick’s (2007) summary of the findings of the authoritative CATIE trials was discussed:

The most stunning finding was that psychiatrists tend to ignore life-threatening, treatable medical conditions in patients presenting for treatment with schizophrenia. ... [the study] did expose a woeful standard in the medical management of schizophrenia offered by psychiatrists.

¹⁹⁵ Thornicroft (2006), p.175.

¹⁹⁶ *Ibid.*, p.97.

¹⁹⁷ *Ibid.*, p.248; see also p.49:

She has suffered financially from her condition, for example by having to pay higher premiums for insurance. “*My endowment policy from my mortgage is a higher rate. I pay more because I’m ill. I think it’s 15-20 per cent more. I disclosed my condition because otherwise you end up not being covered at all!*” Travel insurance is also a continuing problem. “*I had to ring a special line and she said “Well in that case you are not covered for schizophrenia”.*”

€126,000. Another was concerned that medical or professional representatives would not be present during the conference to look after the ‘ill’.¹⁹⁸

B.1.2.2.6: Diminution of rights

Example 1: Thornicroft (2006) in discussing the *European Convention on Human*

Rights states:

... in places it reveals older and deeper prejudices against people with mental illness. Article 5, for example, states that groups of persons of ‘unsound mind’, along with ‘vagrants’ and ‘drug addicts’ are exempted from the protections afforded to others.¹⁹⁹

Example 2: The existence of “*de facto detained*” – those who ‘consented’ to admission as a voluntary patient under threat of being compulsorily detained – has been discussed earlier; the Manweiler case (*supra*) provides one such example; the MHC (2009) Report into Mental Hospitals in Tipperary (*supra*) provides others.²⁰⁰

A Norwegian study which examined the level of “*perceived coercion*”²⁰¹ found that:

Many patients reported high levels of perceived coercion in the admission process, with the involuntary group experiencing significantly higher levels than the voluntary group. However, 32% of voluntarily admitted patients perceived high levels, and 41% of involuntarily admitted patients perceived low levels of coercion. Legal status did not significantly predict perceived coercion ...²⁰²

The findings that the distinction between ‘voluntary’ and ‘involuntary’ is not based on clear legal principles but rather on the *fiat* the medical staff accentuates the experience of “*powerlessness*” which Thornicroft (2006) reports as the “*core issue*”²⁰³ identified by ex-psychiatric patients; he notes:

¹⁹⁸ McGowan, P. (2003). ‘Letters to the Editor: Stigma of mental illness.’ *The Irish Times*. 24 November.

¹⁹⁹ Thornicroft (2006), p.78.

A fuller and more nuanced discussion of the *European Convention on Human Rights* as it relates to the mentally ill, is to be found in O’Neill (2005), p.60 *et seq.*

²⁰⁰ MHC (2009), p.84: “*Although very few residents were detained under the Mental Health Act 2001 several ward doors were locked and staff referred to residents being ‘allowed out’ or given ‘parole’.*”

²⁰¹ Iversen (2002), p.433:

Several studies suggest that the patient’s experience of being coerced, during the admission process to mental hospitals, does not necessarily correspond with their legal status. Rather, perceived coercion appears to be associated with having experienced force and/or threats (negative pressures), as well as feeling that their views were not taken into consideration in the admission process.

²⁰² *Ibid.*

See also Thornicroft (2006), p.153:

Legally speaking, control is only formally taken away while service users are subjected to compulsory legal powers, usually during periods of involuntary admission to hospital. In practice the question of control is much more fluid. A series of recent studies in North America and Europe have shown that even while inpatients are technically admitted on a ‘voluntary’ basis, most understand that they are not fully free to stay or leave as they wish. There is an implied, and sometimes an explicit, threat that if they try to take their discharge against medical advice, they will be legally detained.

²⁰³ *Ibid.*

This power differential has a long and painful history. Involuntary commitment is rarely acknowledged by professionals to be one fundamental element underlying mental health services.²⁰⁴

Such lack of awareness is not uncommon²⁰⁵ and, in the circumstances pertaining, is tantamount to a refusal to acknowledge and thus it is sufficient to merit the term ‘denial’.

B.1.2.2.7: Limitations on court access

Example 1: In Ireland, the limitations²⁰⁶ placed on a plaintiff under S.73 of the *Mental Health Act* (2001) have been discussed earlier; this section effectively prohibits the taking of civil proceedings against psychiatrists for harm caused by their negligence.

Example 2: Thornicroft (2006) gives an example of a woman who “... even found her credibility as a victim of crime questioned because of her mental illness” when she sought to report a burglary:

But he also said, “*You won’t make a credible witness. No Crown Prosecution Service is going to put you on the stand with the record that you have got.*” It wasn’t until this Detective Sergeant agreed that I was “*to be believed*”, despite my record, that I could make an insurance claim.²⁰⁷

Example 3: In 2008, the US Supreme Court, overruling an earlier decision, held that a mentally ill defendant although competent to stand trial, is not necessarily competent to dispense with a lawyer and to represent himself:

Noting that the court has referred to the right to self-representation as an aspect of individual dignity, Justice Breyer said dignity was lacking in the “*spectacle that could well result*” from a mentally ill defendant’s efforts, which he said were “*at least as likely to prove humiliating as ennobling.*”²⁰⁸

In a dissenting judgement, Justice Scalia commented:

The dignity at issue is the supreme human dignity of being master of one’s fate rather than a ward of the state – the dignity of individual choice. ... In singling out

²⁰⁴ *Ibid.*, p.154.

²⁰⁵ See the discussion in the Introduction concerning:

- the paucity of results found in journal searches for occurrences of the term ‘coercion’ in the context of a psychiatric intervention;
- the level of professional denial concerning the extent of coercive psychiatric intervention - e.g. Lieberman (Clinical Professor of Psychiatry at the George Washington University) who writes [Lieberman (2004), p.229]: “*One rarely hears of someone being committed involuntarily to a mental hospital, ...*”.

²⁰⁶ See Appendix A.

²⁰⁷ Thornicroft (2006), p.67.

See also Williams (2009) who reported on the disciplining of two police officers who had failed to record a reported rape as a crime allegedly because the complainant had had mental health problems.

Williams, R. (2009). ‘Failed by police – the woman whose rape complaint was lost in pile of paperwork.’ *The Guardian*. 1 December.

²⁰⁸ Greenhouse, L. (2008). ‘Self-Representation by the Mentally Ill Is Curbed.’ *New York Times*. 20 June.

mentally ill defendants for this treatment, the court's opinion does not even have the questionable virtue of being politically correct.²⁰⁹

B.1.2.2.8: Limitations on voting rights

Example 1: A benchmark study was carried out in the US in 1989, and repeated in 1999, to determine the loss of civil and legal rights suffered by mentally ill and mentally incompetent persons:

The overall trend was towards increasingly curtailed rights. In 1999, 19 of these states limited voting rights for mentally ill people and 12 restricted voting for those assessed to be incompetent.²¹⁰

Example 2: In relation to the UK,²¹¹ Thornicroft (2006) states:

... complex regulations allow inpatients to vote as long as they have a non-hospital address and they have 'capacity' to vote. ... In practice many compulsorily detained patients are disenfranchised. ... The systematic withdrawal of such fundamental rights can be considered a type of 'civil death'.²¹²

Example 3: Sartorius (2002) notes that:

The installation of ballot boxes in mental hospitals is still a rarity even in countries where there is much awareness of the need to protect human rights and social rights of those with mental illness. How should we convince others that most people with mental illness retain many of their capacities and that their rights are often not respected if we do not show the way by our own behaviour?²¹³

B.1.2.2.9: Limitations on jury service

Example 1: O'Neill (2005) notes that the law relating to eligibility for jury service is:

... anachronistic and discriminatory, as there seems to be no logical reason for excluding a person who has suffered from mental illness in the past but has now recovered from jury service nor does there appear to be any good reason for excluding a person whose illness is properly controlled.²¹⁴

B.1.2.2.10: Irrevocability of diagnosis

Example 1: The difficulty in getting a psychiatric diagnosis reversed has been adverted to in earlier chapters and examples, such as described by Witzum (1995b),²¹⁵ show that

²⁰⁹ *Ibid.*

²¹⁰ Thornicroft (2006), p.73.

²¹¹ O'Neill (2005), (p.758) sets out the position relating to Ireland:

Where a person's name is on the electoral register the question of capacity will be one of fact for the officer presiding at the polling station. In the usual course of events, voters are only asked [questions as to their identity] ... and will be permitted to vote if they are capable of answering – the result being unlikely to be challenged.

²¹² Thornicroft (2006), pp.73-4.

²¹³ *Op. cit.*, p.1471.

²¹⁴ *Op. cit.*, p.762:

The effect of ... the *Juries Act* 1976 is that a person who suffers or has suffered from mental disorder or mental disability and on account of that condition either is resident in a hospital or other similar institution or regularly attends for treatment by a medical practitioner is ineligible for jury service.

Similar limitations apply in the UK [see Thornicroft (2006), p.74].

²¹⁵ See Chapter 4 (*supra*).

it is so extreme as to warrant a psychiatric diagnosis being described as, effectively, ‘irrevocable’. The Juklerød case²¹⁶ and Rosenhan (1973)²¹⁷ emphasise the insurmountable hurdle faced by one who wishes to assert that his original diagnosis of, say, schizophrenia was a misdiagnosis and not – as clinicians might maintain – schizophrenia ‘*in remission*.’²¹⁸

Example 2: In 2009, Rosenhan – being incapacitated as a result of a stroke – nominated an academic colleague to speak from his (*i.e.* Rosenhan’s) unpublished notes which described his own repeated trips to psychiatric hospitals using a pseudonym ‘David Lurie’:

Looking through Rosenhan’s notes, it’s clear that the whole experience has had a lasting effect on him. “*Months spent as a pseudo-patient have evoked in me passions that I hardly believed I knew existed,*” he says. He found himself in a Catch-22 situation: even when he told the doctors that he felt better, he still wasn’t allowed to leave. “*The only way out was to point out that they were correct. They said I had been insane, I was insane, but I was getting better. It was an affirmation of their views.*”²¹⁹

B.1.2.2.11: Descriptions of discrimination

Descriptions are given under the following headings:

- ‘dehumanization’ [[B.1.2.2.11.1](#)];
- ‘civil death’ / ‘metaphysical death’ / ‘detritus of a broken brain’ [[B.1.2.2.11.2](#)];
- removal of responsibility [[B.1.2.2.11.3](#)];
- communication dismissed or invalidated [[B.1.2.2.11.4](#)];
- heightened susceptibility to being assessed as dangerous [[B.1.2.2.11.5](#)].

²¹⁶ See Appendix G.

²¹⁷ See Chapter 4 (*supra*). See also Hammond (2009):

None of the decisions to diagnose schizophrenia in the pseudopatients was reversed, even for the patient who had been observed for 52 days. Rosenhan wondered how a doctor who could not even tell which patients had mental health problems could ever expect to distinguish between different types of mental illness.

Hammond, C. (2009). ‘Have psychiatric wards changed?’. *The Times*. 27 July.

²¹⁸ Rosenhan (1973) p.3:

The label “*in remission*” should in no way be dismissed as a formality, ... Nor are there any indications in the hospital records that the pseudopatient’s status was suspect. Rather, the evidence is strong that, once labeled schizophrenic, the pseudopatient was stuck with that label. If the pseudopatient was to be discharged, he must naturally be “*in remission*”; but he was not sane, nor, in the institution’s view, had he ever been sane.

²¹⁹ Hammond (2009) (*supra*) and also:

He found the experience shocking, not because he was able to trick the doctors into admitting him, but because of the way he was treated the moment he had been labelled mentally ill. “*I can still recall my own impulse to go up to the nurses and say, ‘You think I’m David Lurie, well I’m not, I’m David Rosenhan, professor of psychology.’ It was only my anticipation of their likely response - ‘Do you often think you’re a professor of psychology?’ — that stopped me doing it.*”

B.1.2.2.11.1: ‘Dehumanization’

Example 1: Reich (in an essay described by Fulford as “a scholarly tour de force”)²²⁰ under a heading ‘*Diagnosis as Exclusion and Dehumanisation*’ states:

From time to time we all have the urge to exculpate ... to turn deviance into illness: diagnosis does these things, does them magically and utterly, ... we have what we think are the diagnosee’s interests at heart. [But] we also use it because it helps us do things we otherwise could not bring ourselves to do.

He then speaks of how Stalin and Hitler could, by playing on the distinction between “one of us” and “not one of us”, portrayed targeted groups as “*dangerous outsiders*” and turned them into “*objects*”. He then speaks of how terms such as “*crazy*” and “*schizophrenic*” can be used as exclusionary labels to identify others who are “*annoying, discomfoting and different*”. He continues:

Formally applied – that is, by psychiatrists – diagnoses can make a person into someone who seems wholly other, and who requires exclusion. ... In short, a diagnosis can turn him or her into another kind of human being, perhaps less than human, certainly not a fellow human being; ... [who] needs to be put away. ... With such a diagnosis, psychiatrist can proceed, and not have to see themselves as violators of human freedom and dignity.²²¹

B.1.2.2.11.2: ‘Civil death’ / ‘Metaphysical death’ / ‘Detritus of a broken brain’

Example 1: The case of Hannah Greally was described to the Irish Seanad by Senator David Norris:

I remember reading her book *Bird’s Nest Soup*. She was just a girl of high spirits and by the age of 18 was put into the local mental hospital and it took her about 30 or 40 years to get out. She did eventually get out and spent the last years of her life independently. That was a reproach to the whole of our society.²²²

The case has also been the subject of some academic analysis and commentary; Ward (2006), for example, describes *Birds’ Nest Soup*²²³ as: “... a unique, representative record of how Ireland secured the civil death and personal mortification of thousands of its citizens over several decades.”²²⁴

Example 2: Scull (2005) offers a comparable description of psychiatric incarceration: “*To be considered insane is, in many respects, to have suffered a kind of social, mental, and metaphysical death.*”²²⁵

²²⁰ Fulford (2006), p.579.

²²¹ Reich (1999), pp. 210–2. [Emphasis in original].

²²² *Seanad Éireann*, 7 November 2002, at p.748.

²²³ Greally (1971).

²²⁴ Ward (2006), p.66; she adopts Goffman’s (1961) description of involuntary psychiatric detention as being a “*civil death*” a term which is a term also used by Thornicroft (2006) (*supra*).

²²⁵ Scull (2005), p.13.

Example 3: Luhrmann (2000) (*supra*) has described biomedical psychiatry as fostering an attitude to those it treats as being “only as the detritus of a broken brain”.²²⁶

B.1.2.2.11.3: Removal of responsibility

Example 1: Browne,²²⁷ in criticising the overreliance on pharmacology in psychiatry,²²⁸ argues that the belief underlying such treatments is that psychiatric disorders are caused by chemical deficits or imbalances in the brain and that its resolution lies – not in the individual taking control of and seeking to reorientate his life – but in redressing this imbalance.²²⁹ Browne (2008) argues that this attempt to remove responsibility is “lethal”:

The issue here is not the giving of the drug; many psychoactive drugs are very useful on a temporary basis ... It is not the drug, it is the message that accompanies it that is really damaging. Typically, if a person is clinically depressed he is told that whenever he feels depression descending on him he must contact his psychiatrist and commence the appropriate medication. ... this is a lethal message. ... to deprive a person of the very quality of being in control of himself is the worst thing that could be done to him.²³⁰

Example 2: Luhrmann’s (2000) analysis of the distinction between biomedical and psychodynamic psychiatry is similar to Browne’s (2008) in that she regards psychotherapy as holding a patient to be responsible for their actions – and thus respecting that they are ‘persons’ – whereas from the biomedical perspective, they are not. She states:

Biology is the great moral loophole of our age. ... A moral vision that treats the body as choiceless and non-responsible and the mind as choice-making and responsible has significant consequences for a view of mental illness precariously perched between the two.²³¹

Example 3: The report in *The New York Times* of a retired judge who, having admitted to kidnapping the 14-year-old daughter of his former lover, sought to attribute his

²²⁶ Rieder (2001), p.985.

²²⁷ As noted earlier, Ivor Browne was Professor of Psychiatry at UCD.

²²⁸ Browne (2008), p.261:

In dealing with a psychiatric illness there is no treatment that you can apply to a person that will bring about real change in him. The person has to undertake the work himself, and this involves pain and suffering. ... Many psychiatrists seem to have missed this point entirely. They think that, by giving tranquilisers and temporarily relieving symptoms, something has been achieved, whereas in fact no real change has taken place and sooner or later the person will slip back ...

²²⁹ The differing approaches are not necessarily incompatible and may be harmonised by utilising, for example, the ‘Double Aspect Theory’ as found in the philosophy of Spinoza.

An analogy might be of assistance: cleaving to the ‘bio-bio-bio’ model of psychiatry is akin to insisting that physical chastisement is the only appropriate way to manage childhood misbehaviour.

²³⁰ Browne (2008), pp.261–2.

²³¹ Quoted in Rieder (2001), p.985.

behaviour “to psychiatric diagnoses ranging from depression to bipolar disorder”²³² attests to the potency of psychiatric diagnosis as a ‘responsibility removing’ mechanism.

B.1.2.2.11.4: Communication dismissed or invalidated

Example 1: The title of a BBC Radio 4 programme on disability, ‘Does he take sugar?’, encapsulates one aspect of disability: that individuals are viewed as being unable to speak for themselves; a surrogate or intermediary is required. A corollary of such an attitude is that when individuals do speak for themselves, they are not necessarily to be listened to.

The situation of one diagnosed with a psychiatric disorder and subjected to a coercive intervention, is even more extreme²³³ in that the psychiatrist can appropriate to himself the mantle of surrogate; and – as the ultimate judge of the patient’s best interests – become the official ‘voice’ of his patient. Any expression of dissent by the patient, if not dismissed as irrational or meaningless, become evidence of ‘denial’; thus invalidating the possibility of communication.²³⁴ Such attitudes extend beyond those coercively detained as evidenced by the 2008 US Supreme Court case (discussed earlier in this section) where a defendant who, though having a psychiatric disorder, had been adjudged competent to stand trial but was not permitted to speak on his own behalf.

Lest such a conclusion seems unduly extreme consider Read (2003) writing in

Philosophy, Psychiatry, & Psychology:

The least misleading thing to say about cases of severe mental illness is probably that there can be no such thing as understanding them. (And then, of course, no such thing as misunderstanding them either. They just aren't candidates for understanding.) We have no criteria via which cognitively to evaluate them, and so whatever we attempt to say of them by way of affirmative characterization will be arbitrary, and in a way quite misleading.²³⁵

²³² Schemo, D. (1993). ‘Seeking Leniency, Wachtler Blames Adversaries.’ *The New York Times*. 5 September.

²³³ As evidenced by the examples of Juklerød and Manweiler and studies such as Ribeiro (1994) and Rosenhan (1973) discussed earlier.

²³⁴ In its review of Thornicroft (2006) the judges for the BMA Medical Book Competition 2007 state: Once a person is labelled as mentally ill, their decision-making ability is called into question and protests against treatments are either discredited or labelled as one more symptom of mental illness.

[online], available: <http://ukcatalogue.oup.com/product/9780198570981.do> [accessed: 14 September 2009].

²³⁵ *Op. cit.*, pp.122-3. Read also argues [see also Chapter 1 *supra*]:

... that the most impenetrable cases of schizophrenia may be cases not of a sense being made that we cannot grasp, nor of a different form of life, but, despite appearances, of no sense, *no form of life*, at all. [Emphasis in original]

Example 2: Thornicroft (2006) notes that there is a dearth of research²³⁶ into psychiatrist–patient communication:

How far there is agreement between, for example, the psychiatrist’s diagnosis and the view of the person concerned is seldom discussed.²³⁷

Thornicroft cites a meta-analysis²³⁸ of the literature conducted by MIND²³⁹ on ex-psychiatric patients’ assessment of whether they had been ‘listened to’ as patients; it found that:

- (i) Service users’ views were disregarded by researchers if they did not coincide with those of mental health professionals;
- (ii) There was a clear sense in the research that patients are continually irrational and so cannot give a valid opinion;
- (iii) Service users and relatives were assumed to share the same interests (and if they do not, then family views predominated);
- (iv) Some credence was given to the service user’s view only as long as it coincides with the expert’s view.²⁴⁰

Such a refusal to communicate is tantamount to a ‘silencing’.²⁴¹

Though there are, of course, humane psychiatrists willing to patiently listen and deeply engage with their patient’s “*search for meaning*,”²⁴² they are not, it seems, yet in the majority.²⁴³

²³⁶ Thornicroft (2006), p.207:

It might be expected that in relation to mental illnesses where there are especially controversial diagnostic practices and where psychiatrists usually possess legal powers that go well beyond those available to other doctors, that ‘doctor-patient’ communication would have been especially well researched. But this would be a mistaken assumption.

²³⁷ Thornicroft (2006), p.206.

²³⁸ Rogers (1993).

²³⁹ The National Association for Mental Health.

²⁴⁰ Thornicroft (2006), p.154.

²⁴¹ Maitland (2008), pp.26-7:

If I cut your tongue out you are silenced ... ; if I throw you into a dungeon you may shout and yell, but you are still silenced ... ; if I make your speaking worthless, ‘inaudible’, meaningless, ... you are also silenced. ... calling someone ‘mad’, for example, means they can say what they like but no one will hear ...

²⁴² Yawar (2009) (*supra*), p.621:

A patient’s story is a symphony of suffering, longing, meaning, understanding, hope, fear, loss, wit, and wisdom. Not to accompany the person afflicted on his journey is inhumane. ... ‘Schizophrenia’ means several contradictory things, but does not reflect the search for meaning that is at the heart of the disorder.

²⁴³ See, for example, criticism of the ‘bio-bio-bio model’ of psychiatry by Sharfstein (2005) (*supra*) in his Presidential address to the American Psychiatric Association.

See also Bates (2009); Bates (who is Senior Clinical Psychologist at St. James’s Hospital, Dublin) wrote about a friend who had been recently admitted to a psychiatric hospital but whose condition had disimproved:

They gave her weekend leave and she felt worse when she returned. The staff took this to mean she wasn’t strong enough to be discharged and increased her medication. ... I felt concerned that no one around her had allowed her to talk through how she planned to deal with the real practical problems she needed to solve. ... Because no one had taken the time to get to know her as a person, she had become increasingly alienated from her ‘self’. People had tracked her symptoms carefully but it felt to her that this was all they were interested in when they spoke to her.

Bates, T. (2009). ‘Look at the person, not the symptoms.’ *The Irish Times*. 14 April.

B.1.2.2.11.5: Heightened susceptibility to being assessed as dangerous

Example 1: The susceptibility of those who have been diagnosed with a psychiatric disorder (particularly schizophrenia) to coercive intervention on the grounds of their dangerousness whilst others who pose a provably greater danger are exempt, has been discussed in Chapter 6.

I wish to draw the following conclusions from the above discussion:

The discriminations and other detriments consequent on a coercive psychiatric intervention are both extensive and severe.

Though manifold distinctions exist between human persons and non-persons (such as animals or objects), two are pre-eminent: persons are responsible for their actions and they have the ability to communicate.

The adoption of a biomedical model for psychiatry – in that it both removes responsibility and lessens the obligation to communicate – facilitates the taking of a stance towards a mentally troubled individual, as towards an object rather than as towards a person.

B.2: Some effects of coercive psychiatric treatment from the perspective of third party observers

Whilst some such accounts have been mentioned in earlier chapters [e.g. Yawar (2009),²⁴⁴ Leonid Plyushch²⁴⁵], accounts by third party observers are rare and difficult to unearth, accordingly the examples in the following section have something of the flavour of a miscellany.

Example 1: In discussing neuroleptics, the psychiatrist Peter Breggin notes that:

... very little is written in professional sources about the apathy, uninterest, and other lobotomylike effects of the drugs. Review articles tend to give no hint that the medications are actually stupefying the patients ...²⁴⁶

To overcome this limitation he turns to the clinical accounts (from c. 1950s) given by the earliest proponents of neuroleptic treatment. According to its inventors, “*relatively small doses*” of the first neuroleptic (Thorazine) resulted in patients:

Sitting or lying, the patient is motionless in his bed, often pale and with eyelids lowered. He remains silent most of the time. If he is questioned, he answers slowly and deliberately in a monotonous and indifferent voice; he expresses himself in a few words and becomes silent.²⁴⁷

²⁴⁴ Yawar (2009), p.621, (*supra*):

Antipsychotics are, at times, cruel drugs. Some cause shaking, salivation, restlessness, infertility, stiffness, agitation, and frail bones; others cause obesity, somnolence, and increase the risk of heart attack, diabetes, and stroke.

²⁴⁵ The New York Times (1976) (*supra*): “*I became drowsy and apathetic. It became difficult to read books. ... I was horrified to see how I deteriorated intellectually, morally and emotionally ...*”

²⁴⁶ Breggin (1993), p.65.

²⁴⁷ *Ibid.*, p.67.

In the first US report published in the psychiatric literature on neuroleptic treatment, the authors: “*graphically describe the ‘emotional indifference’ and specifically call it the ‘aim’ of the treatment.*”²⁴⁸ and in a later article, one of the authors: “*declared that in some cases ‘chlorpromazine may prove to be a pharmacological substitute for lobotomy.*”²⁴⁹ The most widely read textbook on psychiatry at the time stated: “*If the patient responds well to the drug, he develops an attitude of indifference both to his surroundings and to his syndrome.*”²⁵⁰

Example 2: A much more recent account of patient experiences with non-coercive use of neuroleptics is given in Moncrieff (2009).²⁵¹ Moncrieff (2009), having noted the paucity of studies on patients’ subjective experience of neuroleptics,²⁵² analysed user comments on the effects of both older and newer (*e.g.* olanzapine, risperidone) antipsychotics.

The study found that whilst “*around half of respondents [gave] the drugs a positive or middle rating*”, this appeared to be associated with a desired emotional or cognitive ‘blunting’²⁵³ – the very effects complained of by others – and leading to the observation that:

... the drugs therapeutic effects are not specific to psychotic symptoms but rather may result from a general impact on cognition and emotion.²⁵⁴

... part of the desired, therapeutic effect of antipsychotic drugs is obtained from non-specific, and usually adversely experienced, effects on mental functioning as a whole.²⁵⁵

²⁴⁸ *Ibid.*, p.68.

The quotation is reminiscent of the views of a US psychiatrist writing in the 1940s, that mental illness was often due to having “*too much intelligence.*” [see Corry (2008) *supra*]. See also Myerson (1942) [quoted in Whitaker (2003), p.73]:

I think it may be true that these people have for the time being at any rate more intelligence than they can handle and that the reduction of intelligence is an important factor in the curative process. I say this without cynicism. The fact is that some of the very best cures that one gets are in those individuals whom one reduces almost to amentia [simple-mindedness].

²⁴⁹ *Ibid.*

²⁵⁰ *Ibid.*

²⁵¹ Moncrieff (2009).

²⁵² *Ibid.*, p.103:

... few studies have investigated the experience of taking psychiatric medication from the perspective of the patient ... the nature of the subjective state produced by antipsychotics has not been systematically described.

²⁵³ Moncrieff (2009) gives some examples (p.107):

Example 1: A man who took risperidone for anxiety commented that the drug “*reduced my excessive worrying, but now I don’t seem to care much about anything anymore.*”

Example 2: A woman with anxiety and depression described how she felt olanzapine provided a “*nice ‘buffer’ between my anxiety / emotions and the outside world.*”

Example 3: A man with paranoid schizophrenia wrote how risperidone had “*numbed my brain from psychotic thoughts, flattened most of my emotions.*”

²⁵⁴ *Ibid.*, p.103 and also p.109.

This observation adds further weight to the description (*supra*) of such drugs as being a ‘chemical cosh’.

²⁵⁵ *Ibid.*, p.109.

Of those experiencing negative effects:

- 42% to 56%²⁵⁶ experienced sedation;²⁵⁷
- 17% to 35% experienced cognitive deficits;²⁵⁸
- 12%²⁵⁹ used “*terms such as ‘zombie’, ‘brainwashed’ and ‘braindead’ ... to describe the overall impact of taking antipsychotics.*”²⁶⁰

In contrast, studies have found that: “*clinicians ignore or minimise patients complaints about the negative subjective effects of antipsychotics.*”²⁶¹

Moncrieff (2009) concluded that: “*All three types of drug were reported as inducing depressive and suicidal symptoms by some respondents.*”²⁶² and that:

... different types of antipsychotics produce strikingly similar emotional, motivational and cognitive effects. All appear to produce a state characterised by sedation, flattening of emotional responses, indifference and impaired subjective cognitive functioning. ... All three drugs produced akathisia²⁶³ ... [which] was strongly associated with reporting suicidal thoughts.²⁶⁴

Example 3: In discussing the Juklerød case (*supra*), Dr. Lars Martensson, a psychiatrist, has stated:

If you really love someone, if you get to know them, you won't want to give them neuroleptics. What disappears is exactly what makes them worth loving, their will, their capability to change. There's little comfort in having their symptoms diminish so that they are simply less trouble. The meaning of their life goes, so why should they want to live? Since neuroleptics were introduced patients complain: “*I've become a robot! My life is gray and meaningless.*” All happiness and desire disappear. What neuroleptics do is deprive people of their lives. If anything should be kept sacred it's life, in quotation marks “*the human spirit*”.²⁶⁵

Example 4: In an attempt to understand the subjective effects of antipsychotics, two physicians consented to have a single dose of the antipsychotic, Haloperidol, administered to them. Their report in the *British Journal of Psychiatry*, stated:

²⁵⁶ *I.e.* depending on which of olanzapine, risperidone or the older antipsychotics were being used.

²⁵⁷ *E.g.* “*I feel tired all the time. Too tired to be depressed.*” [*Op. cit.*, Table 3.]

²⁵⁸ *E.g.* “*no thoughts or inner world*”; “*mental fogginess all the time*” [*Ibid.*]

²⁵⁹ Abstracted from Moncrieff (2009), p.104, Table 1.

²⁶⁰ *Op. cit.*, p.107.

²⁶¹ Moncrieff (2009), p.109.

²⁶² *Ibid.*, p.105.

²⁶³ Akathisia: A movement disorder characterized by a feeling of inner restlessness and a compelling need to be in constant motion as well as by actions such as rocking while standing or sitting, lifting the feet as if marching on the spot and crossing and uncrossing the legs while sitting. [online], available: <http://www.medterms.com/script/main/art.asp?articlekey=33264> [accessed: 27 July 2011.].

²⁶⁴ *Ibid.*, p.109.

²⁶⁵ Interviewed in Sandøy (1997).

See also Jansson (1998) who quotes a mother as saying to her daughter's psychiatrist: “*She is my daughter but yet a different person. She is with me in body but her soul is in some way lost.*”

See also Goleman (1985) who, in discussing Lipton & Simon (1985) (*supra*), quoted Dr. Akiskal (a professor of psychiatry) as stating:

Neuroleptics leave people lethargic and unmotivated; they're not their normal selves, ... A creative artist on antidepressants can still be creative, but its unlikely he would be on neuroleptics.

The effect was marked and very similar in both of us: within ten minutes a marked slowing of thinking and movement developed, along with profound inner restlessness. Neither subject could continue work, and each left work for over 36 hours. Each subject complained of a paralysis of volition, a lack of physical and psychic energy. The subjects felt unable to read, telephone or perform household tasks of their own will, but could perform these tasks if demanded to do so. There was no sleepiness or sedation; on the contrary, both subjects complained of severe anxiety.²⁶⁶

Example 5: Seale (2007) examined the consultation process of some psychiatrists as to how the possible adverse effects of antipsychotic treatment were discussed with their patients.²⁶⁷ Despite the fact that these psychiatrists considered themselves to be 'patient-centred' in their practice, the study found that when, for example, 'sleepiness' was presented by a patient as being troublesome:

... patients' reports were sometimes met by doctors offering no response, changing the subject, or disagreeing with the patient's interpretation of the experience.²⁶⁸

Seale (2007) concluded that:

Doctors in these consultations are able to exercise considerable discretion over whether to define reports of sedation and mental clouding as medication-related problems.²⁶⁹

Seale's (2007) results receive confirmation from an unexpected source: a study [Basch (2010)] on the general methodology used in the reporting of side-effects of non-psychiatric drugs; it found that:

The current drug-labeling practice for adverse events is based on the implicit assumption that an accurate portrait of patients' subjective experiences can be provided by clinicians' documentation alone. Yet a substantial body of evidence contradicts this assumption, showing that clinicians systematically downgrade the severity of patients' symptoms, that patients' self-reports frequently capture side effects that clinicians miss, and that clinicians' failure to note these symptoms results in the occurrence of preventable adverse events.²⁷⁰

Interviewed subsequently, Basch commented that:

If patients' comments are sought at all, they are usually filtered through doctors and nurses, who write their own impressions of what patients are feeling. ... there is a sensibility among some old-school clinicians that they have a better sense of their patients experience than patients do themselves.²⁷¹

It is clear that, in relation to psychiatric treatments, such attitudes can only be accentuated.

²⁶⁶ Belmaker & Wald (1977).

²⁶⁷ As a background to their study, Seale (2007) assumed that (p.698):

Sedation and mental clouding are of concern to people on antipsychotic medication and are implicated in social withdrawal but their severity may be underestimated by psychiatrists.

²⁶⁸ *Op. cit.*, p.698.

²⁶⁹ *Ibid.*

²⁷⁰ *Op. cit.*, p.865.

²⁷¹ Grady, D. (2010). 'Tracking side effects of new drugs.' *International Herald Tribune*. 15 April.

The discussion in this section enables the conclusion to be drawn that the extent and severity of the adverse effects of psychoactive medication (especially antipsychotics) may be extreme and are likely to be underestimated both in psychiatric clinical practice and in the professional literature.

Section C: Coercive psychiatric interventions from the perspective of the subject

Three aspects of coercive psychiatric intervention will be discussed: coercive psychiatric detention contrasted with imprisonment [*Subsection C.1*]; the effect of coercive psychiatric detention and treatment on the personhood of the subject [*Subsection C.2*] and, lastly, studies which sought to evaluate subjects' retrospective assessments of having been subjected to coercive treatment [*Subsection C.3*].

C.1: Coercive psychiatric detention vs. imprisonment

In reporting the amount of damages²⁷² awarded in the Manweiler case,²⁷³ Dr. Coulter (the *Irish Times* legal correspondent) sought to contrast it with the amount awarded in respect of the wrongful conviction and imprisonment of a Mr. Shortt. She stated:

While involuntary detention in a psychiatric hospital is a very negative experience, it is arguably less onerous than detention in prison. Also, Mr. Manweiler was not branded a drug-dealer, deprived of his professional standing and generally subject to public odium.²⁷⁴

It is arguable that the stigma suffered by Manweiler (*i.e.* having been misdiagnosed with schizophrenia and coercively detained and medicated) was equal to if not greater than that suffered by Shortt in that Manweiler suffered a diminution of rights far in excess²⁷⁵ of a simple loss of freedom. Furthermore, whilst Shortt's contention that he was innocent might not necessarily have been believed, it would have been listened to and judged worthy of sensible response; in contrast, Manweiler's contention that he was misdiagnosed would have been regarded as a manifestation of his irrationality and as constituting a psychiatric 'denial' and thus confirmatory of the original diagnosis; in this regard, he would have been effectively 'silenced'.

Of even greater seriousness than Manweiler's confinement – and a matter which radically distinguishes it from a wrongful imprisonment – is his forced treatment with

²⁷² Euro 3 million, which, at the time, constituted the highest award of general damages in the history of the State.

²⁷³ See Appendix H.

²⁷⁴ Coulter, C. (2005). 'Unsatisfactory damages neither a deterrent nor a punishment'. *The Irish Times* 13 October; see also Appendix H.

²⁷⁵ See the discussion earlier in this Chapter.

antipsychotic medication.²⁷⁶ Whilst a wrongful confinement may have removed his liberty, the wrongful administration of neuroleptics – in that it rendered him a “zombie”²⁷⁷ for ten years – trespassed deeply on his sense of self and personhood.

Juklerød,²⁷⁸ who (having been released from a mental hospital) spent some time in prison because of his continued protest against his psychiatric diagnosis, was in a position to offer a more authoritative opinion: “*I would prefer to spend three years here²⁷⁹ than one year in Gaustad.²⁸⁰ I’ve spent 12 years there.*”²⁸¹

It was suggested earlier that in some circumstances, a coercive psychiatric intervention might – in the level of its intrusiveness – be compared to a rape and, in pursuing this comparison,²⁸² the damages awarded to Manweiler were contrasted with those awarded to a victim of rape; it was concluded that the respective jury awards lend support to such a comparison.²⁸³

C.2: Effects of coercive psychiatry on personhood

Example 1: Thornicroft (2006) describes the experience of a Ghanaian immigrant to the UK who “... began to give credit to odd beliefs, for example she felt that when she crossed the road that cars swerved to try to run her over.” She was admitted to a psychiatric hospital and forcibly medicated. Over a year later, having recovered from the symptoms (a recovery which she attributes to her strong religious belief), she was still “*very distressed when remembering this episode ... adamant that [it] has irreversibly changed her life.*”²⁸⁴ She describes her experience:

There were between six and eight staff members, I’m not sure, I can’t remember too much. I didn’t have a very clear vision. I saw people surrounding me, holding me by the hand, holding me by the legs. I don’t think it was something they had to do. There was no talking. They would have helped better if they had more understanding and more talking ... more respect. I felt really bad. While I

²⁷⁶ Compare the testimony of detainees at Guantanamo: “*For some released [military] detainees, the forced medication they experienced was the most traumatic part of their captivity.*”

Warrick, J. (2008). ‘Detainees Alleged Being Drugged, Questioned.’ *Washington Post*. 22 April.

²⁷⁷ Browne (2005a).

²⁷⁸ See Appendix G.

²⁷⁹ *I.e.* a prison.

²⁸⁰ *I.e.* a mental hospital.

²⁸¹ Sandøy (1997).

²⁸² See Appendix H.

²⁸³ *Ibid.*

See also Rowley (2009) (who describes herself as a psychiatric ‘survivor’) who compares the coercive use of ECT as being “*akin to rape by machine.*”

Rowley, R. (2009) ‘Letters to the Editor: ECT’. *The Irish Times*. 8 December.

²⁸⁴ Thornicroft (2006), pp. 85-6.

was in hospital I tried to complain but I don't know if anybody was listening. It was a nightmare.²⁸⁵

Though she had been very influential in the local community and was chair of the Education Committee:

I'm no longer the person I used to be. I used to be someone who had leadership qualities. I've lost confidence. I don't want to be the centre any more. I shy away from getting too involved. I used to socialize in my community, then they would be looking at me in a funny way, and for a couple of them, it's like you don't exist any more.²⁸⁶

Example 2: Whitaker (2003) reports on testimony given before a US Senate sub-committee, by two patients who had been coercively medicated with antipsychotics:

Patient 1: [The drugs caused] ... the most fatalistic and despairing moments I've had on this planet. The only way I can describe the despair is that my consciousness was being beaten back ... they prevent you from carrying on thought processes. They hold you in a tight circle of thoughts that never find fulfillment, that never find freedom of expression.

Patient 2: It is very hard to describe the effects of this drug and others like it. That is why we use strange words like zombie. In my case, the experience became sheer torture. Different muscles began twitching uncontrollably. My mouth was like very dry cotton no matter how much water I drank. My tongue became all swollen up. My entire body felt like it was being twisted up in contortions inside by some unseen wringer. And my mind became clouded up and slowed down.²⁸⁷

Others who have had similar experiences, have managed to transcend them, yet others have salvaged something positive from their experience and became academic or clinical psychologists²⁸⁸ [Bentall, May, and Bassman] or advocates for the so-called 'survivor' movement. [Chamberlin²⁸⁹]. Bentall's description has been mentioned earlier: "... *psychiatric patients have been denied a voice by being treated as irrational and dangerous, like wild animals in a zoo.*"²⁹⁰ and Chamberlin (2006) described her experience with the words: "*our basic rights as human beings and citizens had been violated by the very process of psychiatric diagnosis, labelling and treatment, ...*"²⁹¹

²⁸⁵ *Ibid.*, p.87.

²⁸⁶ *Ibid.*, p.85.

²⁸⁷ Whitaker (2003), p.177.

²⁸⁸ For example, Bassman (2000), p.1396:

It is not philosophy, statistics, or brilliant logical arguments that convince me that the medical model of mental illness is dangerous. ... Those of us who were able to come out on the other side of our ordeal know that the medicalization of moral and spiritual questions has become a pathology-based model of mental illness that crushes the spirit and attacks our humanity. We are betrayed by a branch of medicine that blatantly violates its most important principle: Do no harm.

²⁸⁹ Thornicroft, (2006), p.xi (*supra*).

²⁹⁰ Bentall, (2003), p.xiv; See the Introduction for a fuller quotation.

²⁹¹ *Ibid.*

Example 3: As an 18-year-old, Rufus May was diagnosed with schizophrenia and told that he would have to take medication for the rest of his life:

He did take his medication for a while, but became so upset by its disabling sedative effects that he started to refuse. It was then that he experienced psychiatry's powers of compulsory treatment, when six nurses pulled his trousers down to his ankles, pinned him to the ground and injected tranquillisers into one of his buttocks. ... I thought I was treated cruelly. When I was forcibly treated and injected, it felt like rape.²⁹²

He believes that he was treated in hospital like a "*social, moral and genetic outsider*". Subsequently he came off his medication without professional help²⁹³ and thirteen years later he was working as a clinical psychologist.

Example 4: Ronald Bassman, who has practiced as a clinical psychologist for over twenty years,²⁹⁴ has written about his experiences of coercive psychiatry both in books²⁹⁵ and journal articles. Diagnosed with schizophrenia, he describes his coercive treatment:

The seclusion room was empty except for a mattress covered in black rubber on the concrete floor. ... They waited for the drug to take effect before they stripped me of my clothes. I was left naked in the seclusion room, and no explanations were given. They did not tell me how long I would stay there.

Three decades have passed since I've had any kind of psychiatric treatment, yet the memories remain. Even after more than 20 years of work as a licensed psychologist, the nightmares have not disappeared.²⁹⁶

Bassman (2000) focuses on how psychiatry fails to honour the personhood of those subjected to coercive treatment and regards them as '*objects*' or '*non-persons*'. (As mentioned earlier) Bassman describes his first meeting with his psychiatrist:

I looked at my visit to the psychiatrist as a test, an opportunity to vindicate myself and reassure my family. ... I waited for him to speak. It seemed to be a test of wills. ... His bored air and mechanized rote manner of relating to me expressed an undisguised arrogant superiority towards a nonperson. I was an object to be acknowledged, but unworthy of respect. He did not need to attend to the civilities owed to a real person. There was not enough time nor the need for anything more than the face-to-face meeting required for a quick psychiatric evaluation in preparation for commitment.²⁹⁷

²⁹² James, A. (2000). 'Spying on the psychiatrists'. *The Guardian*. 20 September.

²⁹³ May is reported as stating that "*if community treatment orders had been around when I stopped taking medication, I might not be where I am today.*"

Horton, C. (2000). 'Mental health proposals flawed, says ex-psychiatric patient.' *The Guardian*. 21 December.

²⁹⁴ Though he notes that: "*During that time I worked as a clinician and an advocate and did not reveal my psychiatric history for twenty years.*" See [online], available: <http://www.narpa.org/bassman.htm> [accessed: 18 September 2009].

²⁹⁵ Bassman (2007).

²⁹⁶ Bassman (2001).

²⁹⁷ Bassman (2000), pp.1397-8.

He describes his interaction with psychiatrists whilst hospitalised²⁹⁸ and concludes:

Psychiatric hospitalization may be the most damaging and least effective service that can be provided to a person in crisis (transition). ... Admission to a psychiatric facility is a life-defining event that can never be undone. Preventing a person from ever going into the hospital should be the number-one priority when working with people in crisis. Once hospitalized, you are marked with a diagnosis and that label becomes an indelible tattoo burned into your sense of self. Worse still was the knowledge that I could be stripped of everything: memory, identity, dreams, ideals, freedom to move or even to think. All this could be brought about with my tormenters feeling self-righteous, and those who cared for me thinking they were acting in my best interests.²⁹⁹

The above testimonies permit the conclusion:

*The discriminations and other detriments consequent on a coercive psychiatric intervention may entail a deep and possibly life-long, trespass on, and damage to, a subject's personhood.*³⁰⁰

The question of whether it is also possible to speak of a coercive psychiatric intervention 'destroying' a subject's personhood will be addressed in Section D (*infra*).

C.3: Studies which sought to evaluate subjects' retrospective assessments of having been subjected to coercive treatment.

The case of Catherine Shine - an asthmatic who had been forcibly intubated - was discussed by Annas (1999) [see Subsection A.3 *supra*] as was the fact that the Massachusetts State Supreme Court had subsequently held the behaviour of the physicians to be clearly unlawful. A number of physicians responded to Annas (1999) each of whom expressed the opinion that the decision of the original physician to use coercion was correct. One of these [Migden (2000)] related how a patient of a colleague who had originally refused intubation but on whom treatment was forced,

²⁹⁸ *Ibid.*, p.1399:

Some respectful conversation, some regard as a worthwhile person, and I believe I would have been able to orient myself. After my initial treatment, I withdrew to a place inside where I was inaccessible. I had begun to be fitted for my new label, schizophrenia, paranoid type. ... They demanded that I acknowledge the irrationality of my beliefs. Each interview became an interrogation. It didn't matter to them what I believed, but rather the relinquishment of my beliefs and an overt demonstration of my submission to their authority were their prerequisites to progress.

... Looking back I see that self-defeating behavior which got me the most radical and potentially damaging treatments as necessary for me to maintain at least some tiny bit of autonomy and self-respect.

²⁹⁹ *Ibid.*, pp.1401-2; he continues (p. 1403):

Regardless of the complex factors determining one's entrance, coercive drug-reliant psychiatric treatments that masquerade as help destroy hope and generally do not make the tunnels any more tolerable to inhabit, nor easier to exit. ... Listening and trying to understand, accepting a person's experience as valid, and expecting a person to take as much personal responsibility as he or she can are important foundations of programs that attempt to make available alternative services for people facing psychiatric hospitalization.

³⁰⁰ The term 'personhood' has been used here as encompassing Personhood_{ETH} (in the subjective sense *i.e.* Personhood_{ETH-SUBJ}), Personhood_{LAW} and Personhood_{SOC}.

later thanked his physician; Migden concluded: “*How many such outcomes are needed to justify future decisions to intubate patients like Catherine Shine?*”³⁰¹

Responding to Migden, Annas (2000) argued that the patient’s subsequent gratitude “... *has no relevance ... Treatment is legal and ethical at the time it is administered*”³⁰²

Annas not only has law on his side but also logic as quickly becomes evident if the contrary circumstances are considered *i.e.* a patient who originally consents but who subsequent to the operation, seeks to revoke their consent. Nonetheless if it indeed transpired that the vast majority of patients who had been forcibly intubated were subsequently grateful that their wishes had been disregarded, then one might well concede that although the original use of coercion was wrongful and a trespass, it was of a minor nature much like the case of the climber who having suffered altitude sickness, was forcibly brought down the mountain.³⁰³

To reach such a conclusion, it is clear that, *inter alia*, the following two conditions must be met:

Condition 1: The vast majority of such patients must be grateful that the intervention had been undertaken even though it was contrary to their original wishes;

Condition 2: Those who did not express gratitude nonetheless considered the disregard of their original wishes to have been of a relatively minor nature.

Recently some studies have sought to determine the retrospective opinions of individuals who had been subjected to a coercive psychiatric intervention, to the earlier use of coercion. The assessing of retrospective opinions in the context of coercive psychiatric intervention (and of the implications that might reasonably be drawn from such an assessment) is considerably more complex than in respect of forced intubation because, amongst other factors, of the possible fear in a subject that a negative assessment of the use of coercion might suggest that the ‘treatment’ had been ineffective and consequently result in its prolongation. Secondly, the refusal to accede to the wishes of one who refuses intubation is highly circumscribed in that their wishes in all matters other than those connected with intubation will be respected; the refusal to

³⁰¹ See A.3 for a more complete quotation.

³⁰² *Ibid.*

³⁰³ Such ethically non-problematic interventions were mentioned in the Introduction and were termed ‘*quasi-coercive psychiatric interventions*’; they will be discussed further in the Conclusions.

accede to the wishes of one who has been subjected to a forced psychiatric intervention may well be, in contrast, near-absolute.³⁰⁴

A problem which is somewhat analogous to the assessing of retrospective opinions concerning the use of coercive psychiatric interventions will be discussed in Subsection C.3.1; this enables some of the criteria that should govern such retrospective assessments, to be indentified. Some retrospective studies on the opinions of those who have been subjected to the use of coercion in psychiatry, will be discussed in Subsection C.3.2 and these studies will be examined in Subsection C.3.3 in the light of the criteria identified in C.3.1. Some conclusions will be drawn in Subsection C.3.4.

C.3.1: An analogous problem

Before discussing the Priebe (2010) and similar studies it is useful to first consider an analogous problem: the assessing by interview, of teenagers who have been committed to a young offenders institution, as to whether at the time of the interview, they agreed that their incarceration had been justified.

In designing such a study the following criteria are clearly of importance:

Criterion A: that it not be assumed that those who refused to participate in the study manifested the same spectrum of attitudes as those who agreed to participate.

In the absence of convincing evidence to the contrary, the default position should be that all who refused to participate should be included in the ‘unjustified’ category.

Criterion B: that the study be carried out by researchers who were manifestly independent of the institution in question and who were in a position to give an unequivocal assurance that the information garnered from such interviews, in so far as it related to, or might be used to identify, any specific individual, would not be made available to institutional authorities.

If, on the contrary, a participant to the survey was not absolutely convinced of the complete confidentiality of his answers, he might be expected to give a positive response lest a negative response elicit further coercive measures on the basis that the previous intervention had, manifestly, not achieved its desired objective.

³⁰⁴ See Goffman’s description (*supra*) of a forced coercive psychiatric intervention as being a depersonalisation equivalent to a “*mortification*” or a “*civil death*”.

Such an effect might be expected to be exacerbated in relation to involuntarily detained psychiatric subjects because of the possibility of paranoid attitudes amongst such subjects.

Criterion C: the question posed should be sufficiently nuanced so as to permit a subject who agreed that the intervention was beneficial because of some indirect benefit (*e.g.* one previously homeless but now in receipt of food and lodgings), to be distinguished from one who believed that the involuntary nature of the intervention was, of itself, beneficial.

Furthermore the application of such survey techniques to assess retrospective attitudes to a coercive *psychiatric* intervention raises profound additional questions as to how they might be reconciled with studies [B.1.2.2.11.4 *supra*] which have found that psychiatric service users reported that their attempts at communication with psychiatric professionals, were dismissed if they did not coincide with those of the mental health professionals with whom they interacted; the latter appeared to regard the service users as manifesting a persisting irrationality and thus unable to give valid opinions.

How can service users – especially if still subject to an existing or prospective coercive detention – be deemed to manifest such a degree of irrationality as to justify their continuing coercive treatment whilst simultaneously be deemed to manifest such a degree of rationality as to accord validity to their assessment of the appropriateness of their being subjected to coercive intervention?³⁰⁵ A comparison with the climber who had been forcibly brought down the mountain makes clear the difficulty: whilst the climber may have been irrational when at high altitude, there is no suggestion that this irrationality persists at sea-level and thus his answer to the question (at sea-level) as to whether he then agreed that the earlier use of coercion was appropriate, is worthy of consideration; had there been a likelihood that the irrationality might have persisted to sea-level this conclusion would clearly be in doubt. The additional criteria – and clearly such exist – that should apply to surveys which seek to retrospectively assess the views of subjects who had been coercively detained in a psychiatric hospital and whose rationality had been deemed to have been severely compromised (and, presumably, continues to be so deemed), require the careful attention of researchers for their identification. Such is not the task of this dissertation and the criteria whatever they may well be, will for convenience, be simply labelled as Criterion D.

³⁰⁵ And as, for example, in Priebe (2009) where subjects were deemed to have the capacity to give an informed consent to being interviewed whilst contemporaneously being deemed to lack capacity to give an informed consent to (and by necessary implication, to a refusal of) treatment.

C.3.2: Surveys of retrospective opinions on having been subjected to a coercive psychiatric intervention

The following surveys were examined: Priebe (2009), Priebe (2010) and Katsakou (2010).

Priebe (2009)

Priebe (2009) noted that “*little is known about the long-term outcome of involuntary admissions to psychiatric hospitals.*”³⁰⁶ and in an attempt to redress this situation, data was collected at over 22 hospitals, on 1570 involuntarily patients.³⁰⁷ 50% were interviewed within the first week after admission and of these, 51% were re-interviewed after one year.

The study found that, at one year:

Only 40% of patients felt in retrospect that their original involuntary admission was justified, and this percentage might have been even smaller if all patients had been re-interviewed.³⁰⁸

Priebe (2010)

This study was an analysis of a survey conducted in 11 European countries, of 2326 consecutive involuntary psychiatric patients as to whether they retrospectively agreed that their involuntary detention and treatment, had been appropriate.³⁰⁹ The subjects were interviewed within one week of admission; 1809 were followed up one month later and 1613, three months later. The study found that in the different countries, between 39 and 71% felt the admission was right after one month, and between 46 and 86% after three months.³¹⁰

Priebe (2010) also noted a number of points that are of more general interest to the main dissertation argument:

Legislation for involuntary admissions is based on the assumption that individuals cannot recognise the need for hospital care because of the severe and usually acute symptoms of their illness. This would imply that they should later (once the acute phase is over) accept that the involuntary admission was the right intervention at the time.³¹¹

and that:

³⁰⁶ Priebe (2009), p.49.

³⁰⁷ The Priebe (2009) study was “... *the largest national prospective study of involuntary hospitalisation to date*” [*Op. cit.*, p.52].

³⁰⁸ *Ibid.*, p.53.

³⁰⁹ Priebe (2010), p.180.

It is worthy of note that the survey question made no explicit mention of the nature of the intervention *i.e.* terms such as “*coercion*” or “*involuntary*” were not used.

³¹⁰ *Ibid.*, p.179.

³¹¹ *Ibid.*

The findings that a substantial proportion of patients do not agree retrospectively with the appropriateness of the admission may shed a critical light on the ethical justification of involuntary hospital admission. ... what is a totally new finding is the large variation across sites in different European countries.³¹²

In relation to the latter he states:

The findings suggest that the great differences in the legislation and practice of involuntary hospital admission and subsequent treatment across Europe may indeed be associated with substantial differences in patients' views.³¹³

Katsakou (2010)

This study was based on the results of a survey of involuntarily admitted psychiatric patients over 67 acute wards in 22 hospitals in England. A total of 778 involuntary inpatients were recruited, and their satisfaction with treatment was assessed a week after admission and at the one-month, three-month, and one-year follow-ups.

It appears that the respondents were not questioned as to whether they, in retrospect, regarded the original coercive intervention as justifiable but rather asked to rate their satisfaction with their then current treatment³¹⁴ on a scale of 1 to 10; they were also asked to rate the level of coercion that had been used against them on a scale of 0 to 5.

The study found that "*On average, patients' ratings of satisfaction with their treatment were in the positive half (that is, a score over 5) ...*"³¹⁵ though it also noted that:

At all time points participants reported the lowest scores on the item rating satisfaction with their psychiatrist and the highest scores on the item rating satisfaction with other staff.³¹⁶

The study concluded:

Patients' perceptions of coercion were consistently associated with treatment satisfaction, with those reporting less coercion overall (both at admission and during the first month of treatment) and not having experienced coercive measures (such as restraint, forced medication, and seclusion) being more satisfied.³¹⁷

³¹² *Ibid.*, p.182.

³¹³ *Ibid.*, p.184. An appendix to Priebe (2010) ranks the legislation on involuntary hospital admission across the 11 countries, by the degree of protection of subjects' rights. The study found a correlation between the level of subject's acceptance of involuntary intervention and the extent of the subject's legal rights (e.g. "*Does involuntary admission require the decision of a court or not?*").

³¹⁴ Katsakou (2010), p.286:

"Do you believe you are receiving the right treatment for you?"

"Does your psychiatrist understand you and is he/she engaged in your treatment?"...

"Do you feel respected and regarded well?"

³¹⁵ *Ibid.*, p.290.

³¹⁶ *Ibid.*, p.288.

³¹⁷ *Ibid.*, p.290.

C.3.3: The surveys examined in the light of the C.3.1 criteria

Criterion A:

Priebe (2009) summarises his results by stating “*At 1 year ... 40% considered their original admission justified*”. Yet an examination of the data shows that of the 1,050 initially contacted, 244 refused (23%); at one year, a further 122 refused. Thus of the 396 interviewed at one year, 158 “*considered their admission justified.*” A more conservative reading of this data might suggest that only 15% of the original sample population were clearly shown to believe that their admission was justified [*i.e.* 158/1,050 = 0.15 (15%)]

In relation to Priebe (2010) an examination of the data shows that 4,651 patients were eligible of whom 3,152 were asked to take part and of whom 826 refused (26%). Of those who took part 22% were not interviewed at one-month and 31% not interviewed at three-month. 1,613 participated at conclusion of which 1,016 “*agreed the intervention was right*”. A more impartial reading would include most if not all, of the refusals with those who disagreed and would yield a figure considerably less than was reported.

Katsakou’s (2010) study initially had 1,570 eligible subjects, of whom 778 gave consent; of these 396 were interviewed at one-year. This study is again open to the objection that the refusals were ignored in the analysis though, of the three studies, Katsakou (2010) is alone in acknowledging this limitation.³¹⁸

None of the above studies listed the complete findings in relation to the 10-point satisfaction scale that had been used but rather aggregated the findings into ranges ‘under 5’ and ‘5 and over’. This has the effect of masking those who strongly disagreed (*e.g.* 0 or 1) and it could be argued that not only are such results of considerable analytical importance but that they should be given greater weight in the final calculations (*e.g.* by using a weighted average).

Criterion B:

None of these studies satisfied Criterion B.

Priebe (2009):

On receipt of information on new admissions, researchers asked the ward staff for consent to contact patients. The researchers then approached the eligible patients and invited them to participate in the study.³¹⁹

³¹⁸ *Ibid.*, p.290: “*One might, however, speculate as to whether patients who refused to participate in interviews were less satisfied with treatment*”.

³¹⁹ Priebe (2009), p.49.

Priebe (2010):

Clinical staff in the participating wards introduced eligible patients to a researcher, who contacted the patient within the first week of admission, provided a full explanation of the study, and asked for consent.³²⁰

Katsakou (2010) does not discuss the status of researchers.

Rose (2011) sought to examine whether data on perceived coercion, collected by researchers who were service users differed from data collected by researchers who were non-service users. It found no difference; however, the methodology used by Rose (2011) fell far short of satisfying Criterion B.

This criterion was implicitly addressed in an editorial in *Psychiatric Services* entitled 'Coercion Is Not Mental Health Care', where LeBel (2011a)³²¹ argued that research in the area of coercion should be conducted only by those who have had first hand experience of such coercion:

Why has no one conducted a comparative analysis of consumers' perception of coercion? One need only consult with the experts – consumers themselves – to understand why. They offered the following explanation: 1) discrimination, 2) discrimination, and 3) discrimination. They also agreed: "*Coercion is in the eye of the beholder,*" and the orientation of the researcher biases the study. Research findings are inherently flawed – and our understanding of coercion along with them – unless the study and the data analysis are conducted by consumers who have experienced coercion.³²²

In reply to a criticism of her editorial stance, LeBel (2011b) responded:

More important than debating who should claim the high ground in coercion research is appreciating the damaging effects of coercion on individuals who receive care. These effects have been well articulated and should be taken as the sentinel call to recognizing that coercive practices thwart the purpose of mental health services – to facilitate recovery by improving a person's mental health condition and functioning – and have no place in a treatment paradigm.³²³

Criterion C:

The possibility that a positive response to the survey question was occasioned by an indirect benefit (*e.g.* adequate food and lodgings) rather than by satisfaction with the nature of the intervention *per se* was not addressed in any meaningful sense in any of the surveys. Priebe (2009) and Priebe (2010) appear to offer conflicting conclusions on the relevance of a subject living alone prior to the coercive intervention:

³²⁰ Priebe (2010), p.180.

³²¹ This editorial accompanied the publication of Newton-Howes & Mullen (2011) which was a systematic review of the literature on coercion as covered in MEDLINE, PsycINFO, and CINAHL. The authors concluded that (p.465): "*The final analysis included 27 articles. Themes related to perceived coercion were almost all negative. ... Coercion was commonly felt by patients as dehumanizing.*"

³²² LeBel (2011a), p.453.

³²³ LeBel (2011b), p.807.

Priebe (2009): At the same time, people living alone are more likely to consider their original admission justified, possibly because they particularly value the company and social support during and after hospital care and, subsequently, have a more positive view of that experience.³²⁴

Priebe (2010): Patients living alone more often rated the admission as wrong, which may reflect their difficulties adjusting to the confined space and the often tense atmosphere with fellow patients and staff on a ward. It may also be that patients living with others had often experienced conflicts and tension with these making the admission a relief and therefore the right decision in retrospect.³²⁵

An examination of the data underlying Katsakou's (2010) study shows that 7% of the interviewed sample were homeless at the time of the interview which raises the question as to whether the perceived satisfaction of previously homeless subjects was with the coercive intervention itself or with their no longer being homeless. van Baars (2010) – which was a Dutch study of perceived benefit following coercive treatment – found a high relationship between perceived benefit and homelessness.³²⁶

It is of note that the format of the question posed by Priebe (2010)³²⁷ makes no *explicit* mention of coercion and thus precludes the coercive nature of the intervention being distinguished from the more indirect effects of hospitalisation such as the provision of adequate food and lodgings.

Criterion D:

The problems underpinning Criterion D were not adverted to let alone addressed in any of the surveys; the need for explication of the conditions that should comprise Criterion D is clear and this omission is a serious failure.

C.3.4: The studies: conclusions

None of the surveys – Priebe (2009), Priebe (2010) and Katsakou (2010) – adequately addressed, let alone satisfied, any of the criteria A, B, C or D. Furthermore all of the surveys aggregated their survey findings into ranges 'under 5' and '5 and over'; this has the effect of masking those who strongly disagreed. Thus whilst an attempt might be made to argue that Condition 1 of Subsection 3.1 had been satisfied, Condition 2 has clearly not.

In conclusion, the surveys can offer but the barest support to any contention that, considered generally, coercive psychiatric interventions are of a relatively minor

³²⁴ *Op. cit.*, p.52.

³²⁵ *Op. cit.*, p.184.

³²⁶ van Baars (2010), p.1024: "At one year, 52% of patients evaluated their involuntary hospitalization as beneficial. These patients were more likely to be homeless (odds ratio [OR]=4.13) ..."

³²⁷ Priebe (2010), p.180: "Patients rated their response to the question 'Today, do you find it right or wrong that you were admitted to hospital?' on an 11-point Likert scale ranging from 0 (entirely wrong) to 10 (entirely right) ...".

seriousness which might be compared to the forcibly bringing down the mountain of the climber suffering from altitude illness.

Section D: Can a coercive psychiatric intervention be said to ‘destroy’ a subject’s personhood?

A thought experiment is first considered [*Subsection D.1*] and then modified [*Subsection D.2*] before drawing a final conclusion [*Subsection D.3*].

D.1: A thought experiment

As discussed earlier Leonid Plyushch was coercively detained and treated in a Soviet psychiatric hospital allegedly because of his political opinions; in the event, he was released and travelled to the United States and publicised both his own case and that of fellow dissidents. A thought experiment which changes the actual outcome of the Plyushch case, may assist in drawing conclusions from the earlier discussion in this chapter.

Imagine that Plyushch’s case had received no publicity and that he had not been released from hospital but had been detained and coercively medicated with antipsychotics, until his death. Years later, a researcher examining the Plyushch file discovered that his incarceration and coercive treatment had been based on an erroneous psychiatric diagnosis. Bearing in mind not only Plyushch’s lost freedom, his loss of rights, his inability to challenge his diagnosis in court, his being viewed as ‘irrational’ and incapable of meaningful discourse but also the loss of his mental faculties³²⁸ by virtue of the forced administration of antipsychotics, could one not say that his personhood had been ‘destroyed’?

As noted earlier³²⁹, the term ‘destroyed’ does not imply that every trace of the original has been obliterated, rather one means that although vestiges of the original structure may still be glimpsed, it is damaged beyond repair: destroyed. Understood thus, Plyushch’s personhood could rightly be said to have been so grievously damaged as to be destroyed.³³⁰

The existence of the political forces that decreed Plyushch’s committal might perhaps mitigate this judgement in that his gaolers and psychiatrists might have been aware of

³²⁸ See *supra*: “I became drowsy and apathetic. It became difficult to read books. ... I was horrified to see how I deteriorated intellectually, morally and emotionally from day to day.”

³²⁹ See the note at the beginning of this chapter on the use of the term ‘destroyed’.

³³⁰ *I.e.* where Plyushch’s lived experience (both to himself and others) of being a ‘person’ has been destroyed; more formally, Personhood_{ETH} (in the subjective sense *i.e.* Personhood_{ETH-SUBJ}), Personhood_{LAW} and Personhood_{SOC} are so subverted as to be destroyed.

these circumstances and would not have regarded him as ‘irrational’ and beyond the pale of sensible communication; but no such mitigating circumstances could arise in a second thought experiment based on the Manweiler case.³³¹

D.2: A second thought experiment

As a second thought experiment assume that Manweiler had not had the fortuitous access to his hospital file that he had in fact had; if so, he would not have succeeded in his legal action, indeed it is doubtful if his legal proceedings could even have commenced. In that event, Manweiler’s diagnosis of schizophrenia would have remained on his file as would the erroneous assessment that he presented a danger to others; in all likelihood he would have been forced to continue his medication – with all its attendant, mentally deadening, effects [like a “zombie” (*supra*)] – until he died. If, for the purposes of argument, such a scenario is accepted then if Plyushch’s personhood could be said to be destroyed, *a fortiori*, Manweiler’s personhood would also have been destroyed and even more thoroughly than Plyushch’s in that no such mitigating circumstances existed.

D.3: Conclusion

Manweiler is not alone in being the subject of a psychiatric misdiagnosis precipitating coercive detention and treatment and many of these can surely also be said to have their personhood destroyed.

But is the existence of a psychiatric *misdiagnosis* leading to a coercive intervention, crucial to this conclusion? Namely, if a psychiatric diagnosis was correct could it also lead to a destruction of personhood?

It is clear that cases exist where the destruction of personhood preceded³³² any psychiatric intervention, coercive or otherwise. It is also clear that psychiatric conditions exist [*e.g.* Alzheimer’s or dementia] whose onset can be predicted [*i.e.* by a diagnosis]; but such cases are not in issue because, although the destruction of personhood may have followed a coercive psychiatric intervention, it was not *caused* by it. The conclusion that follows from the earlier discussion in this chapter is that cases certainly exist where a subject’s personhood – which was substantially unimpaired before any psychiatric intervention – was so grievously diminished as to be destroyed by a coercive psychiatric detention and the coercive administration of drugs such as neuroleptics.

³³¹ See *supra* and Appendix H.

³³² Such as a preexisting state of severe irrationality or inability to communicate.

Conclusions

*I am not yet born, console me.
I fear that the human race may with tall walls wall me, with strong
drugs dope me, with wise lies lure me, on black racks rack me, ...
I am not yet born; O hear me,
Let not the man who is beast or who thinks he is God come near me. ...
Let them not make me a stone and let them not spill me.
Otherwise kill me.*

Lines from a poem by Louis MacNeice¹

The development of the dissertation argument is summarised in [Section A](#); the dissertation conclusions and proposals are given in [Section B](#).

Section A: A summary of dissertation argument

A.1: The problem

The focus of this dissertation is an examination of the validity of the justification commonly offered for a coercive psychiatric intervention,² namely that the intervention was in the ‘best interests’ of the subject and/or that the subject posed a danger to others. The term ‘coercive’ (rather than ‘non-consensual’) is used to indicate an intervention carried out against the explicit and contemporaneous objections of the subject.

A2: The gravity of some issues posed by coercive psychiatry

Before subjecting the phenomenon of coercive psychiatric intervention to any philosophical or ethical analysis, it is useful to have some indication of its prevalence and the effectiveness, or otherwise, of the (mainly legal) mechanisms which exist to monitor its use or to enable one subjected to a wrongful coercive psychiatric intervention, to seek redress. I have taken the Republic of Ireland as providing a convenient background for discussing the prevalence of coercive practices in psychiatry and the non-psychiatric mechanisms that exist for its supervision; this does not place any constraints on the subsequent philosophical and ethical analysis in that such a discussion would transcend the particularities of any individual legal system.

¹ From ‘Prayer before Birth’ in MacNeice (1945), p.13.

² The acts of coercive treatment being discussed relate to sustained medical interventions and not to isolated acts of restraint such as discussed in the Introduction which included, for example, that of a climber suffering from altitude sickness, being forcibly brought down the mountain; interventions of this latter type were termed ‘*quasi-coercive interventions*’. They are also discussed in Section B (*infra*).

Numerical extent of coercive interventions

The number of individuals detained in Irish psychiatric hospitals is of a comparable order of magnitude to the number detained in Irish prisons subsequent to a criminal conviction. For example, in 2004 over 3,000 were involuntarily detained in psychiatric hospitals whereas c.5,000 were imprisoned subsequent to a criminal conviction; in 2009, the figures were *circa* 2,000 and 11,000 respectively.

Some other³ legal consequences of a coercive psychiatric intervention

Despite the loss of liberty involved in both imprisonment and involuntary detention, the attitude adopted by the Irish legal system towards cases of psychiatric committal stands in stark contrast to that adopted towards criminal cases where imprisonment is a possible consequence; in the former, the courts defer to psychiatric opinion⁴ and manifest an unwillingness to subject it to critical scrutiny; in the latter, the courts insist on assiduously examining the evidence against an accused; they evince considerable scepticism towards the unsubstantiated opinions of prosecutors and – being ever mindful of the harm occasioned by the loss of liberty involved in a wrongful imprisonment – resolve any doubt in favour of the accused.

The contrasting attitudes adopted by the courts is also manifested in other areas of the law, for example:

- in relation Mental Health legislation the courts are unsympathetic towards objections based on ‘technical’ breaches of the law, whilst in criminal matters, they readily accede to such objections even in less than meritorious cases.⁵
- in relation to civil suits: a plaintiff seeking redress for a wrongful or negligent psychiatric intervention must first seek the leave of the courts before commencing legal proceedings and, secondly, cannot succeed by establishing simple negligence but must prove that the defendant “*defendant acted in bad faith or without reasonable care;*”⁶ on the other hand, plaintiffs seeking redress for medical non-psychiatric or other non-medical harms, suffer no such barriers.

The justification generally offered by the courts for its non-interventionist stance is that committals under mental health legislation – in contrast to imprisonment on conviction – are essentially paternalistic in nature. Such attitudes are difficult to sustain in the

³ *I.e.* other than the loss of freedom.

⁴ In other than those criminal cases where a conflict of expert psychiatric evidence occurs; see, for example, the O’Donnell case discussed in Chapter 4.

⁵ For example, the Judge Curtin child pornography case as discussed in the Introduction.

⁶ S. 73, *The Mental Health Act* (2001).

presence of rates of radical misdiagnosis⁷ of the order of 25%⁸ and of the not inconsequential risk of iatrogenic harm⁹ that may be a consequence of psychiatric treatment. In view of the less than glorious history of coercive psychiatry and the brutality of some of its past practices, the unwillingness of the judiciary to extend its critical scrutiny to psychiatric coercion, stands comparison with the unwillingness of an earlier generation of jurists to investigate detentions in institutions such as the Magdalene laundries – a reluctance which was also justified under the guise of paternalism.

The unwillingness of the Irish courts to descend ‘into the arena’ and subject psychiatric determinations to a critical scrutiny is peculiar to psychiatry in that the courts readily adopt a sceptical attitude towards medical testimony in non-psychiatric cases, even in cases where coercive treatment is contemplated as, for example, the giving of life sustaining blood transfusions to non-consenting Jehovah Witnesses. Such unwillingness has the result that a legal challenge to a psychiatric diagnosis, to an involuntary detention,¹⁰ to forced psychoactive treatment or to an assessment of dangerousness is most unlikely to succeed.¹¹

The unwillingness to fully confront the gravity and extent of coercive psychiatric practices is not restricted to the legal profession but also extends to psychiatry where – as discussed in the Introduction – the concept of ‘coercion’ is so underexplored in both psychiatric journals and textbooks, and its extent so minimised, as to merit the description ‘denial’.¹²

Some of the terms used in relation to coercive psychiatric intervention – *e.g.* ‘diagnosis’, ‘treatment’ – import an aura of precision and exactitude and of beneficence that facilitate the adoption of paternalistic attitudes. As discussed in the Introduction, it is necessary that this veil of words be punctured and these terms must also be understood in a wider sense as encompassing mechanisms whereby ‘*some people are picked out*’ and, having been chosen, ‘*things are done to them*’. The term

⁷ A ‘radical’ misdiagnosis is a psychiatric misdiagnosis which precipitated a psychiatric committal in circumstances where the committal would not otherwise have occurred. See Chapters 4 and 5.

⁸ See Chapter 4.

⁹ See Chapter 5.

¹⁰ Though an involuntary detention can be challenged in the Mental Health Tribunals established under the *Mental Health Act* (2001); these tribunals lack the power to reverse an erroneous diagnosis or assessment of dangerousness.

¹¹ See references to Hoggett (1990) and Keys (2002) in Chapter 4.

¹² Though there is evidence that this situation is changing and that a new generation of psychiatrists are more willing to turn a critical gaze on the use of coercion in clinical psychiatry; see especially the discussion in Chapter 7, Subsection C.3.2.

‘dangerousness’ – especially in the context of psychiatric risk assessments – is similarly capable of importing a spurious aura of exactitude.

A.3: An informal sketch of the argument structure

The philosophical well-spring of the dissertation argument lay in an observation made by Philippa Foot that the “... *right to be let free from unwanted interference*” is one of the most fundamental and distinctive rights of persons, a right which takes precedence over any “... *action we would dearly like to take for his sake.*”¹³ Such a perspective clearly precludes any attempt to justify a coercive intervention in terms of the ‘best interests’ (*simpliciter*) of another. In her essay, Foot did not elaborate on the meaning of the term ‘person’ but implicitly differentiated between it and the term ‘human’ as is evident from her discussion of vegetative state patients.¹⁴

To assist in the formulation of the dissertation argument it was presumed that the term ‘person’ could be defined by a set of necessary and sufficient conditions of which ‘minimum levels of rationality’ and ‘ability to communicate’ were the only conditions relevant to the formulation of justifications for coercive psychiatric interventions. This presumption was explicated into a number of postulates¹⁵ which provided a foundation for the development of the dissertation argument.

The formal adoption of these postulates was essentially a heuristic device to enable the capture of a problem which has shown itself to be particularly elusive; it permitted the development of a logically rigorous analysis of possible justifications for coercive psychiatric interventions where, once the initial steps are accepted, the argument proceeds along a well-defined path where the possible objections are tightly constrained – a considerable gain in a field where many arguments are open to being derailed by innumerable side winds with the resulting discussion quickly becoming inchoate.¹⁶

¹³ See Foot (1977), p.102.

¹⁴ *Ibid.* p.111. See Introduction.

¹⁵ See Chapter 1:

Postulate 1. Personhood can be defined by a set of necessary and sufficient conditions which include criteria as to minimum levels of rationality and ability to communicate.

Postulate 2. From amongst such sets of conditions, a set is chosen such that the only conditions relevant to justifying a coercive psychiatric intervention, are ‘rationality’ and ‘ability to communicate’.

Postulate 3. [Foot (1977)] The ascription of personhood confers a rights-cluster the most fundamental of which is ‘the right to life’; a key element of the right to life is the ‘right to be let alone.’

¹⁶ For example, in arguments based on autonomy, objections to a coercive psychiatric intervention on the grounds that it damages the autonomy of the subject can be met with the riposte that the goal of the intervention is to ensure that (after successful treatment) a more securely grounded autonomy can be established; the speciousness of such arguments is more readily apparent when translated into the political field as when a country decides to invade another in order to replace its government by one more

Once established, the argument can, I believe, be recast and restructured to sit on broader foundations. However this is a task for another day.

The postulates have as a corollary that the taking of an action against a subject on the grounds of their ‘best interests’ and which has as a consequence, the ‘destruction’ or ‘grievous diminishment’¹⁷, of the personhood of the subject, can only be justified if at least one of the necessary and sufficient conditions for personhood¹⁸ have not been met which – in relation to a coercive psychiatric intervention – means that either the rationality criterion or the ability to communicate criterion must have been breached *prior* to the intervention.

In decisions by the Irish courts to dismiss challenges to coercive psychiatric interventions, two issues are often commingled: ‘dangerousness’ and ‘paternalism’. The conflation of these issues severely compromises – if not precludes – a rigorous analysis of the legal, and ethical, principles that should govern coercive psychiatric interventions. In order to forestall such a development, the dissertation argument was structured into three stages:

Stage 1: examines coercive psychiatric interventions undertaken *solely* in the interests of the subject;

Stage 2: examines coercive psychiatric interventions undertaken *solely* in the interests of others;

Stage 3: examines coercive psychiatric interventions undertaken on mixed grounds – *i.e.* both in the interests of the subject and in the interests of others.

The argument proceeded on the basis that though some coercive psychiatric interventions might be of such a minor nature as to be comparable to the case of the climber with altitude sickness being forcibly brought down the mountain [these were termed ‘*quasi-coercive interventions*’], others could be of a level of gravity and intrusiveness as to amount to the ‘diminishment’ or ‘destruction’ (*infra*) of the personhood of the subject;¹⁹ that this was indeed the case was established in Chapter 7. The analysis of the possible justifications for such interventions is dependent on which of the Stage 1, 2 and 3 arguments is being evoked and will be discussed below.

autonomous and independent; however, an ‘autonomy’ which exists at the will of another can no longer be called ‘autonomy’.

¹⁷ See the discussion of these terms in the Introduction and Chapter 1.

¹⁸ In the sense of Personhood_{ETH}.

¹⁹ The various meanings of the term ‘personhood’ have been discussed in the Introduction and Chapters 1 and 7 where the terms ‘diminishment of personhood’ and ‘destruction of personhood’ have also been explained.

The absence of adequate data – on, for examples, rates of psychiatric misdiagnosis – raised considerable methodological problems at various stages during the analysis. Viewed from a more abstract perspective, the problem concerns the choice of default presumptions and implicitly poses the question: *In case of doubt, in whose favour or in what manner, or based on what principles should the doubt be resolved?* The principle adopted in the dissertation, was the ‘*Precautionary Principle*’ which is to the effect that once the possibility of a harmful outcome²⁰ has been established, the probability of its occurrence should not, in the absence of further evidence, be assumed to be minimal but that the burden of proof be reversed and the risks be taken to be the higher of the available risk estimates.

A.4: Outline of the development of the dissertation argument

A.4.1: The development of the Stage 1 argument

The problem posed by the Stage 1 argument was to examine how a coercive psychiatric intervention undertaken solely on the grounds of a subject’s best interests, could be justified if it resulted in the destruction, or grievous diminishment, of the subject’s personhood; that such cases existed was demonstrated. As outlined above, the justification must be based on showing that *prior* to the intervention, the subject manifested a level of irrationality or inability to communicate sufficient to put his personhood in jeopardy.

The argument was developed in relation to the rationality criterion²¹ and first sought to determine the level of irrationality [L₂] that psychiatrists would regard as a threshold, the crossing of which would be sufficient to precipitate a coercive intervention. Once this level was established, it could be compared with the level of irrationality sufficient to put personhood in jeopardy [L₁] and the adequacy or otherwise of the purported justification would be immediately evident.

In seeking to determine L₂ an examination of psychiatric journals and textbooks was undertaken²² to determine how clinical psychiatrists used the term ‘irrationality’ in the context of a coercive intervention; it was concluded that not only is it not generally used with any degree of precision or awareness of possible nuances of meaning, but its usage is essentially colloquial.

An examination of clinical psychiatric practice in relation to the concept of ‘delusion’ offered an alternative approach to determining L₂ in that firstly, a delusion is widely

²⁰ *I.e.* a psychiatric misdiagnosis or iatrogenic illness.

²¹ An argument based on the ability to communicate criterion would have a similar structure.

²² In Chapter 2 and Appendix N.

considered to be a paradigm of irrationality and secondly, the diagnosis of delusion is often regarded as sufficient²³ to precipitate a coercive psychiatric intervention. The conclusions drawn²⁴ were, however, that the clinical diagnosis of delusion (by virtue of the use of the justifiability criterion) often occurred in circumstances not in accord with the diagnostic criteria for delusion as specified in the diagnostic manuals such as *DSM-IV* (2000) and, furthermore, that that a diagnosis of delusion does not necessarily imply that the subject evinced *any* irrationality let alone sufficient to put personhood in jeopardy.

It was then sought to attack the problem indirectly: namely to see whether psychiatric determinations in other areas of their claimed professional expertise – *e.g.* psychiatric diagnosis²⁵, assessments of the evidence base for psychiatric treatments²⁶ and psychiatric assessments of dangerousness²⁷ – manifested a reliability and accuracy that was such as to inspire confidence in their professional assessment that a subject was manifestly irrational.

An examination of psychiatric diagnostic practices found a poor level of reliability²⁸, and that many of the diagnostic categories were of questionable validity. Moreover, the rate of radical misdiagnosis (*i.e.* a misdiagnosis which precipitated a coercive intervention which would not have occurred in the absence of such a diagnosis) was estimated to be of the order of 25% of all such coercive interventions.

An examination of psychiatric treatment practices showed that many supposedly evidence-based studies supporting the psychiatric use of, for example, antipsychotics, were deeply flawed and that psychiatrists manifested a reluctance to changing their prescribing habits in the face of authoritative disconfirming evidence relating to the safety and efficacy of the drugs in question.

These results – and similar results (see *infra*) in relation to psychiatric assessments of dangerousness – suggests that psychiatric determinations of irrationality are unreliable and that, consequently, a psychiatric assertion that a subject manifested a level of irrationality sufficient to put his personhood in jeopardy, is also unreliable. It also follows that justifications for coercive psychiatric interventions which are based on

²³ *E.g.* Fulford's (2006) discussion of delusions of jealousy. [See Chapter 3].

²⁴ See Chapter 3.

²⁵ See Chapter 4.

²⁶ See Chapter 5.

²⁷ See Chapter 6.

²⁸ I am using the term 'reliability' in its usual meaning; it has, however, become usual in psychiatric discussion of diagnostic practices to use it as meaning 'consistency'. [See Chapter 4 and *infra*]

psychiatric assessments of the level of irrationality manifested by the subject, may be of doubtful validity.

A.4.2: The development of the Stage 2 argument

The problem posed by the Stage 2 argument was to assess whether psychiatric determinations that a subject posed such a level of dangerousness to others as to require his detention, are reliable.

It was concluded that the error rate encountered in the psychiatric assessment of dangerousness has been estimated as being between 80% and 93% depending on the criterion used to define 'violence' and that the use of such assessments has been advocated by some eminent academic psychiatrists who appeared to be either unwilling or unable to appreciate either the high rate of error involved in psychiatric risk assessment or the extremely serious consequences that might befall anyone subjected to such an erroneous assessment of dangerousness.

It was also concluded that the fact that other subgroups who posed a provably higher risk of violence to others (*e.g.* through drug or alcohol dependence) than those who had a psychiatric history, were exempt from detention,²⁹ was such as to amount to a diminution of the personhood of the latter and could not be justified.

A.4.3: The development of the Stage 3 argument

The Stage 3 argument is only of relevance in situations where a coercive psychiatric intervention cannot be justified:

- on the grounds of manifest irrationality of a degree sufficient to permit a 'best interests' intervention – *i.e.* a Stage 1 argument; or
- on the grounds of manifest dangerousness to others of a degree sufficient to permit an intervention under a Stage 2 argument.

In view of the fact that psychiatric assessments of irrationality and dangerousness are so imprecise, the conclusion can only be drawn that if a situation is such that a psychiatrist feels unable to justify a coercive intervention on the grounds of either irrationality or dangerousness (considered singly) then any attempt to justify it under an amalgam of both should be dismissed out of hand.

²⁹ See, for example, the *Mental Health Act* (2001), S. 8(2):

Nothing in subsection (1) shall be construed as authorising the involuntary admission of a person to an approved centre by reason only of the fact that the person
... (c) is addicted to drugs or intoxicants.

[See also Appendix A].

In conclusion, if a coercive psychiatric intervention cannot be justified by a Stage 1 argument nor by a Stage 2 argument, then the conclusion must be drawn that it can have no justification.

Section B: The dissertation conclusions and proposals

This dissertation was in the nature of a propaedeutic – *i.e.* an attempt to lay bare the problem's underlying structure, to disentangle its various strands and thus enable its complexity to become manifest; accordingly the conclusions are more in the nature of a 'bringing to light' aspects of a problem, rather than an offering of full solutions.

B.1: Conclusions and Proposals: Philosophy of Psychiatry

B.1.1: Conclusions: Philosophy of Psychiatry

Papineau's admonition to his professional philosophical colleagues that they desist from using common sense as the benchmark for testing philosophical theories has been noted in an earlier chapter;³⁰ this warning is of even greater importance in relation to the philosophy of psychiatry in that many of the now accepted 'abuses' of psychiatry – or, more accurately, 'psychiatric abuses'³¹ – occurred because what are now seen as acts of eccentricity or of social or political dissent, were then regarded by psychiatry as pathological behaviours which possibly resulted in coercive intervention.

Many professional philosophers appear to show little awareness of the possibility of such consequences; Wolfgang Blankenburg, for example, states:

Common sense can be defined as practical understanding, capacity to see and take things in their right light, sound judgment, or ordinary mental capacity. ... In schizophrenia, however, there seems to be a true abdication of common sense involving a loss of "*natural self-evidence*." Even in premorbid states, such persons often lose both the sense of tact and the ability to "*take things in their right light*."³²

In a world where coercive intervention was an relatively unknown adjunct to clinical psychiatric practice, no objection might be raised to a phenomenological analysis such as Blankenburg's, but this is not the world in which we find ourselves and to, even tentatively, proffer a deficiency of common sense as a marker for psychiatric illness and thus as a possible identifier for coercive psychiatric intervention, indicates if not an abdication of responsibility, a level of blindness towards the possible consequences of one's utterances.

³⁰ See Chapter 3.

³¹ See Appendix G.

³² Blankenburg (2001), p. 303; see also Appendix F and the discussion of 'orthodoxy' in Chapter 3.

Blankenburg's oversights pale into insignificance in comparison with those such as Professor Hansen (a professor of philosophy and a member of the Executive Council of the *Association for the Advancement of Philosophy and Psychiatry*) who – as quoted in the Introduction – spoke of:

- The biomedical model is now the way things are done in psychiatry; ... Once something becomes “*normal science*” there is no time for philosophical debates.³³
- ... the amazing work that philosophers have done to ... shore up psychiatry against attacks by those who claim it a pseudo-science, ...³⁴
- The hope is that philosophers and psychiatrists can form a partnership to counteract the growing critics of the field.³⁵

Hansen's attitude surely embodies an abdication of the role proper to a philosophy of psychiatry, namely to critically scrutinise psychiatry both in its theory and practice; philosophy should not be the handmaiden of psychiatry, still less its apologist.

Hansen's short-sightedness in so far as it relates to psychiatry is all-embracing; other philosophers exhibit a less extensive myopia, though no less worthy of criticism. Two such examples are:

- Freedman (2007a)³⁶ who argues that one who claims to be a victim of sexual abuse by her father but who can recall no evidential details, should be believed by virtue of, *inter alia*, the “*universality of the everydayness of sexual violence*”. Freedman is either unaware of, or oblivious to the fact that, placing full credence in the testimony of the daughter *necessarily* condemns the father.
- Berrios (1991) who seeks to categorise psychiatric delusions as “*empty speech acts*”³⁷ and Read (2003)³⁸ who classes “*impenetrable cases of schizophrenia*” (in words which carry a disturbing echo the Nazi slogan “*life unworthy of life*”) as “... *despite appearances, of no sense, no form of life, at all.*”³⁹

Statements such as these, seem not only unworthy of philosophy, but egregiously irresponsible when set beside studies such as Ribeiro⁴⁰ (which cast doubt on the reliability of psychiatric assessments of incoherence) or Kingdon (which found that

³³ Hansen (2007), p.3.

³⁴ *Ibid.*

³⁵ *Ibid.*, p.5.

³⁶ See Chapter 3.

³⁷ *Op. cit.*, p.8.

³⁸ See Chapter 3.

³⁹ *Op. cit.*, p.115. [Emphasis in original].

⁴⁰ Ribeiro (1994); see Chapter 2.

nearly half of psychiatrists surveyed considered the misdiagnosis of schizophrenia in black people, to be common.)⁴¹

As discussed in the Introduction, Olofsson in a sociological analysis of the regulation of professions such as medicine and psychiatry, argued that self-regulation was inadequate and that the presence of a strong countervailing force was required in order that these professions be sufficiently held to account; philosophy – especially the discipline of philosophy of psychiatry, is eminently suited to being that countervailing force yet, in its present incarnation as an apologist for psychiatry, it cannot fulfil that role.

B.1.2: Proposals: Philosophy of Psychiatry

(i) Whereas lawyers may seek to defend specific individuals against particular psychiatric trespasses; the philosophy of psychiatry should take upon itself a similar, but more abstract, role; its focus being – not the individual trespass occasioned by a particular coercive psychiatric intervention, but – the reconceptualisation of psychiatry in such a manner that the safeguarding of the personhood of those whom psychiatry treats, becomes of paramount importance; the goal being that no longer may psychiatry stand accused of treating those with whom it interacts as “*non-persons*” or “*objects*”.⁴²

More specific proposals are that the philosophy of psychiatry should :

(ii) relinquish its seemingly dominant, reflexively deferential role towards psychiatry, its practices or its claim to scientific status and reclaim the intellectual independence characteristic of the discipline of philosophy;

(iii) recognise that the use of coercion in psychiatry raises profound ethical questions which require meticulous scrutiny and rigorous justification and that in attempting to answer such questions, the philosophy of psychiatry must ‘cross the threshold’ and examine at first hand the mechanisms whereby ‘people are chosen’ and ‘things done to them’ in the name of psychiatry.

(iv) recognise the seriousness of the consequences that may flow from unbridled speculation and temper its more extreme tendencies [*e.g.* “*no from of life*” (*supra*)].

⁴¹ Kingdon (2004); see Chapter 4.

⁴² See Luhrmann (2000) (*supra*) who has described biomedical psychiatry as fostering an attitude to those it treats as being “*only as the detritus of a broken brain*”.

On a wider note, may I tentatively suggest⁴³ a possible avenue whereby the manifold problems⁴⁴ concerning the definition of delusion (and the loss of personhood that may be consequent on its diagnosis) may be put on a more secure footing; the suggestion draws on the writings of Wittgenstein and Strawson.

Though the claims of orthodoxy are, in relation to the diagnosis of delusion, so overweening as to be insupportable,⁴⁵ there is a core idea which is defensible and which would be useful in the construction of an adequate definition of delusion. This core is best expressed by the metaphor of the “*river bed*” which Wittgenstein develops in his *On Certainty*⁴⁶ to describe those propositions which are the bedrock on which social interaction is constructed. It is not possible to doubt such propositions; a refusal to accept such propositions is tantamount to excluding oneself from society and the possibility of social intercourse.

An analogy may assist: various mathematical disciplines (such as geometry and set theory) are developed on an axiomatic model whereby a theory is constructed from a given set of axioms by a process of deduction. To participate in the theory one must necessarily accept the axioms; this acceptance cannot be justified from within the theory because the axioms are the very precondition for the existence of the theory. Any attempt to cast doubt on these axioms must necessarily be made from outside the theory, in some higher or meta-theory.

Wittgenstein usage of bedrock propositions in discussing a particular culture is similar to the usage of axioms in discussing set theory, they are beyond justification from within that culture:

But I did not get my picture of the world by satisfying myself of its correctness; nor do I have it because I am satisfied of its correctness. No: it is the inherited background against which I distinguish between true and false.⁴⁷

But that means I want to conceive it as something that lies beyond being justified or unjustified; as it were, as something animal.⁴⁸

To refuse to acknowledge such propositions is to exclude oneself from society:

I, L. W., believe, am sure, that my friend hasn't sawdust in his body or in his head, even though I have no direct evidence of my senses to the contrary. I am sure, by reason of what has been said to me, of what I have read, and of my

⁴³ Subsequent to writing this section, I found that Sass (1994) had also drawn on the writings of Wittgenstein in seeking to clarify the concept of delusion.

⁴⁴ See Chapter 3.

⁴⁵ See Chapter 3 and Appendix E.

⁴⁶ See Wittgenstein (1969), p.15e.

⁴⁷ *Op. cit.*, para. 94.

⁴⁸ *Op. cit.*, para. 359.

experience. To have doubts about it would seem to me madness – of course, this is also in agreement with other people; but *I* agree with them.⁴⁹

Wittgenstein's ideas are of especial interest in that the connection between the doubting of these bedrock propositions and the loss of personhood is clear, especially when allied with Strawson's concept of 'person'.

Strawson argues⁵⁰ that personhood arises through a process of mutuality between two individuals when each 'sees himself' in the other; the denial by one such individual of a bedrock proposition (*e.g.* by believing that the other individual actually has sawdust in his head) would effectively subvert the arising of the requisite mutuality and thus preclude the ascription of personhood.

B.2: Conclusions and Proposals: Psychiatry

A scenario

Consider the following scenario: X who has been misdiagnosed with schizophrenia⁵¹ and in consequence of this diagnosis been involuntarily detained and coercively treated. X's protest against his diagnosis is unlikely⁵² to be considered on its merits but rather will be interpreted as being a denial of his illness; this 'denial' may become new and independent evidence of the supposed correctness of the original diagnosis.⁵³ X having been coercively medicated with antipsychotics, suffers side effects which may mimic psychosis⁵⁴ thus making the reversal of the original misdiagnosis even more unlikely. The effect of sustained administration of antipsychotics may cause obesity, diabetes and an increased risk of stroke and heart disease.⁵⁵ X's brain may also be damaged.⁵⁶ It is

⁴⁹ *Op. cit.*, para. 281. [Emphasis in original].

⁵⁰ According to Strawson the concept of person is primitive and cannot be defined in terms of other, more basic, concepts; the ascription of personhood is possible only "... because I am a person amongst others. [Strawson (1963), p.103]

Support for such an approach can be garnered from the etymology of the word 'person' which links it to '*persona*' meaning the 'mask' or role that an individual wears in society. Such a mask embodies a template for how an individual should act so that others may be generally able to predict his responses to typical situations; the coherence of a society is dependent on the existence and constancy of such masks. To act in an unpredictable manner – to jettison one's social mask – is a possible definition of irrationality; it would have, as a consequence, the possible loss of personhood and this opens up another avenue for investigating the link between personhood, irrationality and mental disorder. See also Wittgenstein (1998): "*Madness doesn't have to be regarded as an illness. Why not as a sudden – more or less sudden – change of character?*" (p.62e), [Emphasis in original].

⁵¹ The rate of misdiagnosis of schizophrenia has been estimated as being of the order of 25% [See Chapter 4].

⁵² See the Witztum papers discussed in Chapter 4; see also the Rosenhan experiment discussed in Chapter 4 and the Juklerød case discussed in Appendix G.

⁵³ See Chapter 4 and Amador & Strauss (1993): "*In work with patients with schizophrenia, denial of illness is so common ... that it has become integral to our concept of this disorder.*"

⁵⁴ See Appendix L where Stalman (2002) indicates that the severity of the extrapyramidal symptom of akathisia (internal restlessness) may be of such a severity as to "*clinically mimic psychosis.*"

⁵⁵ See Appendices J and L and, in particular, Yawar (2009):

likely that these medical conditions will not only be left untreated by psychiatrists, but ignored.⁵⁷ Furthermore, it is extremely unlikely that the (Irish) legal system can provide X with mechanisms to enable his situation to be remedied.

In discussing the situation of a Soviet dissident wrongfully detained in a psychiatric hospital⁵⁸ Bloch & Reddaway (1984) commented that: “*The prospect of being placed compulsorily in a psychiatric hospital as a healthy person is so ghastly as to be almost unimaginable.*”⁵⁹ One might pose the rhetorical question as to whether it is any less ghastly when a scenario such as outlined in the previous paragraphs, occurs in a Western European psychiatric hospital some 20 years later?

The Manweiler case⁶⁰ which by an unusual concatenation of circumstances came before the Irish courts in 2005, concerned an individual who was wrongly diagnosed, wrongly committed, and wrongly medicated for a period close to ten years and to an extent that he described the effect of the antipsychotic medication as rendering him like a “*zombie*”.

The case is of interest here – not for its individual circumstances – but for the manner in which it was perceived by a group of eminent Irish psychiatrists who discussed the case in an extended radio interview⁶¹ subsequent to the court verdict in favour of Manweiler. The only note of regret expressed by these psychiatrists was for the psychiatrist who had wrongly committed Manweiler: “*One wonders about the charitableness or the fairness of such a cross examination of a man who is retired.*”⁶² To them, the fact that the psychiatrist in question had considered himself to be acting in the ‘best interests’ of

Antipsychotics are, at times, cruel drugs. Some cause shaking, salivation, restlessness, infertility, stiffness, agitation, and frail bones; others cause obesity, somnolence, and increase the risk of heart attack, diabetes, and stroke.

⁵⁶ Research on the link between antipsychotic use and brain damage has reached no consensus and suggestions of a direct link have been strongly contested; though Ho (2011) found evidence for such a link and concluded that: “*Viewed together with data from animal studies, our study suggests that antipsychotics have a subtle but measurable influence on brain tissue loss over time.*” Goff (2011) suggests that Ho (2011) may have underestimated the loss of brain tissue. Goff noted that monkeys treated with antipsychotics over a period 17-27 months, lost roughly 10% of their total brain volume – a finding which offers strong *prima facie* evidence that the use of antipsychotics itself (*i.e.* separate from the effect of any psychiatric illness) causes brain damage.

⁵⁷ See Appendix L and also Beck quoted *supra*:

The most stunning finding was that psychiatrists tend to ignore life-threatening, treatable medical conditions in patients presenting for treatment with schizophrenia. Of patients entering the study, 45% had untreated diabetes, 89% had untreated hyperlipidemias and 62% had untreated hypertension. ... [CATIE] did expose a woeful standard in the medical management of schizophrenia offered by psychiatrists

⁵⁸ See Chapter 7.

⁵⁹ Bloch & Reddaway (1984), p.29; see also Chapter 7.

⁶⁰ See Appendix H.

⁶¹ See Browne (2005a) excerpts from which are given in Appendix H.

⁶² *Ibid.*

Manweiler, was sufficient to exonerate him from all blame. Such attitudes offers scant hope that cases such as Manweiler’s might not continue to reoccur.

Though many of the dissertation conclusions and proposals in relation to psychiatric practice are implicit in the above scenario, they will now be stated more explicitly.

B.2.1: Conclusions: Psychiatry

Inadequate Data

(i) (*In relation to Ireland*): The maintenance of complete, accurate and up-to-date records in relation to coercive psychiatric interventions is an obvious precondition for the monitoring of such interventions; yet such data has been found to be lacking⁶³ in relation to medical notes,⁶⁴ diagnosis,⁶⁵ treatment,⁶⁶ treatment plans,⁶⁷ injuries to patients,⁶⁸ and non-compliance with legal regulations.⁶⁹

(ii) (*Generally*): Data in relation to psychiatric misdiagnosis and iatrogenic harm consequent on psychiatric treatment is extremely limited; this compounds the difficulty of estimating levels of misdiagnosis, including radical misdiagnosis and unwarranted psychiatric pre-diagnosis.⁷⁰

To obviate these difficulties, it was necessary to tackle the problem indirectly by,

⁶³ This refers to practices in Irish psychiatric hospitals.

⁶⁴ See Appendix I *infra*:

The Inspectorate is concerned about the adequacy and quality of medical note taking ... particularly to consultant inputs both on, or shortly after, admission to hospital and subsequent clinical reviews and progress. [Walsh (1998), pp.3-4.]

⁶⁵ See Chapter 4 *supra*: “*Unfortunately, 15% of residents had no diagnosis returned. This is due in large part to the practice in some inpatient facilities of not recording a diagnosis until discharge.*” [MHC (2005), p.40].

⁶⁶ See Appendix I *infra*:

... drug prescribing in some locations is often arbitrary and made without regard to appropriate clinical diagnosis. ... In some instances, the prescriptions had not been reviewed for some considerable time. [Walsh (1998), pp.3-4.]

See also Chapter 5 *supra*: a report on St. Luke’s Hospital, Clonmel found that: “*On the day of the inspection, the Inspectorate had serious concerns regarding the care and treatment of residents in St. Bridget’s Ward and St. John’s Ward.*” [MHC (2008a), p.2]

⁶⁷ A report on the acute psychiatric unit at the Mater Hospital in Dublin, stated:

It was disappointing to note that for the past three inspection reports there had been only minimal improvement noted in the provision of individual care plans and therapeutic programmes.

The Irish Times (2009). ‘Behind Closed Doors: Extracts of reports from the Inspectorate of Mental Health Service on psychiatric facilities during 2009.’ *The Irish Times*. 28 December.

⁶⁸ See Chapter 6 concerning a report [MHC (2009)] into allegations of ill-treatment of patients in two mental hospitals in County Tipperary.

⁶⁹ Report on the Mater Hospital (*supra*):

Non-compliance with the rules on the use of mechanical restraint, seclusion and ECT was of concern and was in breach of the rights afforded to residents as part of the Mental Health Act, 2001.

⁷⁰ *I.e.* the stage prior to actual diagnosis when it is determined that a subject is ‘mentally ill’ [See Chapter 4].

for example, the use of the Precautionary Principle⁷¹ and (in relation to the extent of inappropriate involuntary committal) an analysis of comparative statistics.⁷² On the limited occasions when research on the extent of psychiatric misdiagnosis is conducted, it tends to underestimate the problem. Stone (2005) – which was the *only* result of a full text search for occurrences of the term ‘psychiatric misdiagnosis’ in the *British Medical Journal* over a period of 25 years – is a particularly egregious example; the study sought to estimate the misdiagnosis of conversion symptoms, yet was grievously deficient both in its methodology and in its conclusions.⁷³

Normalcy

- (i) The concept of normalcy, whether understood as a psychological ideal to be strived for or as a statistical construct, is poorly researched within psychiatry with the result that the term is often used as being little more than a synonym for social conformity.⁷⁴
- (ii) Deficiencies in the understanding of mental normalcy has as a necessary consequence, that the understanding of mental pathology is deficient.⁷⁵

Diagnostic categories

- (i) The choice of diagnostic categories appears to sometimes embody a level of informality⁷⁶ that shows scant awareness⁷⁷ for the consequences of diagnosing a subject as being mentally ill.

⁷¹ See Chapter 1.

⁷² See Chapter 4 [and *infra*] where the extremely wide variations in rates of involuntary committal, were discussed.

⁷³ Stone (2005) is discussed in Chapter 4.

⁷⁴ See Chapter 3 and, in particular, Wiggins & Schwartz (1999):

American psychiatrists rarely study mentally healthy people. ... Psychiatry lacks a conception of healthy mental life; *i.e.*, it lacks an understanding of psychological normalcy. As a result, most aspects of patients' lives are perceived in pathological terms. ... There exist large numbers of mental health experts ... who are prepared to misdiagnose nonconformity as a mental disorder.

See also Frances & Spitzer (2009) [Chapter 4 *supra*] who criticised the DSM5 draft for: “*been insensitive to the great risks of false positives, of medicalizing normality, and of trivializing the whole concept of psychiatric diagnosis.*”

⁷⁵ See Chapter 3, 4 and Appendix E.

See also Angell (2011a); Marcia Angell (the ex Editor-in-Chief of *The New England Journal of Medicine*) has criticised the apparent “*raging epidemic*” of diagnosed psychiatric illness:

A large survey of randomly selected adults, sponsored by the National Institute of Mental Health (NIMH) and conducted between 2001 and 2003, found that an astonishing 46 percent met criteria established by the American Psychiatric Association (APA) for having had at least one mental illness within four broad categories at some time in their lives. ... Most met criteria for more than one diagnosis.

⁷⁶ See Chapter 4 (*supra*): “... *one criterion was dropped because a workgroup member piped up with ‘I do that sometimes.’*” [Ritchie (1989), p.698.]

⁷⁷ See Chapter 4 and, in particular:

(ii) Though diagnostic criteria are reported in the psychiatric literature as permitting high levels of reliability, this is misleading in that the term ‘reliability’ is being used as a synonym for ‘consistency’; the crucial concept of validity often receiving scant attention.⁷⁸

Diagnostic practices

(i) The rate of misdiagnosis of schizophrenia (and consequently⁷⁹ of radical misdiagnosis) is 25%.

(ii) Whether due to a misplaced allegiance to professional colleagues or to hubris, psychiatrists manifest an unwillingness to concede⁸⁰ the not insubstantial possibility of radical misdiagnosis; in consequence protestations against a coercive intervention from one who has been (wrongly) diagnosed are likely to be not only dismissed⁸¹ but regarded as further evidence of mental illness.⁸²

(iii) Clinical psychiatrists sometimes employ diagnostic criteria other than those specified in the diagnostic manuals; this occurs, for example, in relation to the use of the justifiability criterion in the diagnosis of delusion⁸³ and as a result, the mounting of a challenge to such a diagnosis is fraught with difficulty.

– the trenchant criticisms of Allen Frances who was the chairman of the *DSM-IV* Task Force; Frances (2010) suggested that in relation to some *DSM-V* [draft] diagnostic categories: “*The false positive rate would be alarming – 70%.*”

– Spitzer and Frances who in a letter to the APA, stated:

The suggested subthreshold and premorbid diagnoses ... could add tens of millions of newly diagnosed “patients” – the majority of whom would likely be false positives subjected to the needless side effects and expense of treatment. [Frances & Spitzer (2009).]

⁷⁸ See Chapter 4.

See also Angell (2011b); Angell has criticised such a usage as being misleading:

... reliability is not the same thing as validity. Reliability, as I have noted, is used to mean consistency; validity refers to correctness or soundness. If nearly all physicians agreed that freckles were a sign of cancer, the diagnosis would be “*reliable*,” but not valid.

⁷⁹ See Chapter 4.

⁸⁰ Or where misdiagnosis is conceded it is attributed to *other* psychiatrists [see the discussion concerning Kingdon (2004) in Chapter 7].

⁸¹ See Chapter 4 and, in particular, the discussion of the Rosenhan experiment; see also the Juklerød case discussed in Appendix G; both describe the situation where prior to release, a subject must disavow their earlier claim that their psychiatric diagnosis was incorrect. A not dissimilar ritual was required of Soviet dissidents [see Chapter 7]:

“*Release requires recantation*” might well be their slogan ... “*admit openly and officially to the doctors that you were sick – yes, I was ill, yes; I didn’t know what I was doing...*” [Bloch & Reddaway (1984), p.28].

A similar acknowledgement of the correctness of their conviction, is usually required of those seeking parole from prison; see, for example, the report by Aeberhard (2010) which is discussed in Chapter 4.

⁸² *I.e.* ‘denial’.

⁸³ See Chapter 3.

Coercive practices

- (i) There appears to be a level of denial within academic psychiatry of the extent to which coercion is used in psychiatric practice.⁸⁴
- (ii) The extremely wide variations in rates of involuntary committal⁸⁵ (for example, forty seven fold between EU countries) indicates that the rate of psychiatric misdiagnosis precipitating coercive intervention, is substantial.
- (iii) There is a lack of awareness amongst psychiatrists that a psychiatric intervention which depends on the use of coercion *necessarily* causes harm which is not ameliorated by the fact that the intervening psychiatrist sincerely believes the intervention to be in the best interests of the subject.

Psychiatric treatments⁸⁶

- (i) By analogy with the forcibly taking a climber who is suffering from altitude sickness, down the mountain (a coercive act which – though a trespass – is nonetheless of a minor nature and is without danger of damaging personhood), it was recognised that some psychiatric forcible interventions – which were termed ‘*quasi-coercive interventions*’⁸⁷ – might similarly be regarded as of a minor nature and devoid of the possibility of damaging personhood. There is considerable difficulty in attempting to demarcate the boundary between such ‘quasi-coercive interventions’ and coercive psychiatric interventions which put personhood under threat of damage, however some tentative indicators may be suggested:

⁸⁴ See Introduction, though see Chapter 7 Subsection C.3.2 in relation to changing attitudes .

⁸⁵ See Chapter 4 where the following conclusion was drawn:

The extremely wide variations in rates of involuntary committal:

- within Ireland (four-fold);
- between Ireland and other EU countries (thirteen-fold greater than the lowest; the highest was three-fold greater than Ireland);
- between EU countries (‘forty seven’-fold);
- between Scandinavian countries (seven-fold);

are such as to be indicative of a lack of awareness within European clinical psychiatry of the seriousness of the consequences that such an intervention may entail and the consequent requirement for adequate, rigorously assessed, justification.

Such extreme differences in the prevalence rates of involuntary psychiatric detention provides *prima facie* grounds for concluding that, across Europe, the rate of psychiatric misdiagnosis precipitating coercive intervention, is substantial.

⁸⁶ The conclusions in the following subsection have been drawn from Chapter 5; Appendix I (Iatrogenic harm and misdiagnosis in general medicine); Appendix J (Pharmaceutical company influence on psychiatric research); Appendix K (Problematic aspects of antidepressant research) and Appendix L (Problematic aspects of antipsychotic research).

⁸⁷ As discussed in the Introduction, to name such interventions by a term such as ‘*paternalistic*’ risks masking the fact that – in Foot’s analysis – they trespass against justice and furthermore risks carrying the implication that interventions are permissible if they are undertaken for paternalistic reasons. Such a conclusion would be diametrically opposed to Foot’s analysis and the standpoint being adopted in this dissertation accordingly such interventions are termed ‘*quasi-coercive interventions*’ so that both the coercive nature of the intervention is patent as is the fact that they are permissible only because the level of coercion employed is minor and tightly circumscribed.

(a) The brevity of the intervention is no guarantee that it should be regarded as being of a more minor nature; this is clearly exemplified in the brief but forcible, intubation of Catherine Shine (*supra*).⁸⁸

(b) A distinction made by Katsakou (2010)⁸⁹ between ‘*coercion*’ and ‘*perceived coercion*’⁹⁰ would appear to be of especial relevance:

... when patients perceive procedural justice (that is, when their opinions are heard and taken into account ...) and feel persuaded rather than forced or threatened, they feel less coerced, even under objectively coercive circumstances.⁹¹

(c) Building on Katsakou’s distinction, the more a subject is treated as a responsible person and not – in Luhrmann’s words (*supra*) – “*only as the detritus of a broken brain*”, then the lower the level of perceived coercion. Binswanger (*supra*)⁹² and Oury and Mordini (*infra*)⁹³ might well be taken as exemplars of the requisite therapeutic attitudes as might the case history related by Browne (2008) (*supra*).⁹⁴

(ii) The primary obligation placed on a psychiatrist by the principle ‘*Primum non nocere*’ has generally been understood by clinical psychiatrists as simply implying that the benefits to the subject, of any proposed treatment must outweigh the harms.⁹⁵ The thesis being advanced in this dissertation is that this principle should be reinterpreted in a preclusive sense as implying that the primary obligation placed on a psychiatrist by the principle, is to do no harm.⁹⁶ This interpretation was proposed for two main reasons:

⁸⁸ See Chapter 7, Subsection A.3. Similarly the gravity of a sexual assault is not lessened by reason only of its brevity.

⁸⁹ See Chapter 7, Subsection C.3.2.

⁹⁰ It should be noted that it is levels of *perceived coercion* rather than objective measures of coercion that would most closely correlate with threats to Personhood_{ETH-SUBJ} (and thus of Personhood_{ETH}) and that are of most relevance to the dissertation argument.

⁹¹ *Op. cit.*, p.291.

⁹² See Introduction, Subsection C.2.

⁹³ See Subsection B.2.2 (*infra*).

⁹⁴ See Chapter 5, Section D.

⁹⁵ *I.e.* the ‘best interests’ or ‘benefits/detriments’ criterion.

⁹⁶ As discussed in Chapter 5, this statement requires a degree of refinement:

(i) in stating that the injunction to help has priority it is not suggested that this should be interpreted as permitting a disregarding of any harms that may ensue but rather as requiring that the harms which may be occasioned by the treatment are judged to be outweighed by its benefits;

(ii) the statement that the injunction to do no harm has priority, should be understood subject to the following:

Firstly, the term ‘harm’ requires a gloss: transient harms [*i.e.* discomfort] need to be distinguished from more serious harms, the latter being those that, if long lasting, a psychiatrist would be unwilling to countenance in his own life unless offset by very substantial, and proven, benefits; these serious harms might be better described by the term ‘impairments’. The irreversibility of a harm is also relevant in assessing its seriousness; the default assumption being that it should be deemed to be serious unless the contrary is clearly shown.

Secondly, harms which are of such a nature as to be outweighed by the benefits of treatment, are defeasible either by the consent of the subject or by a court.

(a) in relation to consensual treatment: it ensured the necessity of obtaining a subject's informed consent before the commencement of treatment thus removing from the clinician's shoulders the responsibility not to cause a harm if that harm was a foreseen possible consequence of the treatment. Thus the reinterpreted principle is – unlike the 'best interests' principle – in accord with modern legal requirements.

(b) in relation to coercive treatment: it raised a significant barrier against the re-emergence of psychiatric treatments such as lobotomy which had been justified on the 'best interests' interpretation of the principle; the hope being that a later generation cannot look back at now current psychiatric treatments, with shock and disbelief – as now accorded to 'treatments' such as lobotomy – that they had not only been widely used but regarded as embodying a therapeutic ideal.

Thus, in relation to a proposed coercive treatment, the maxim implies that the psychiatrist is under an obligation to ensure⁹⁷ that the proposed treatment will not entail any impairment.⁹⁸ In circumstances where the psychiatrist is unable to give such an assurance, then a number of alternatives are possible:

1. It should be noted that a coercive detention does not necessarily imply that all subsequent treatment decisions must be coercive; it may well be that the subject is competent to consent to a proposed treatment. It is clearly of importance that the procedures used in making any such assessment of competence be fully documented.
2. The subject may have, when competent, executed a power of attorney; if so, the exercise of any such power of attorney should be regarded as final though subject to review by a court.
3. The subject may have, when competent, executed an advance directive covering a treatment decision such as that proposed; the

⁹⁷ The psychiatrist must be 'well-nigh certain' that impairment will not result; the phrase "well-nigh certain" is intended to describe circumstances where not only is it the belief of the vast majority of clinicians that such an intervention will not cause impairment but that no (minority) school of clinicians exists, which argues that it would cause impairment. Thus, for example, whilst the majority of clinical psychiatrists might believe that the use of ECT causes no impairment; a minority (see *supra*) believe that it does; accordingly it could not be said of ECT that it is "well-nigh certain" that it does not cause impairment.

⁹⁸ See Chapter 5 where it was pointed out that transient harms (*e.g.* discomfort) need to be distinguished from more serious harms, the latter being those that, if long lasting, a psychiatrist would be unwilling to countenance in his own life unless offset by very substantial, and proven, benefits; the term 'impairment' was used to refer to such serious harms.

exercise of any such power of attorney should be regarded as final though subject to review by a court.

4. In all other cases the treatment decision must be referred to a court.⁹⁹ This can be achieved either by a process whereby the clinician automatically refers the decision to the court for its decision [*automatic referral*] or by a process whereby the subject is entitled to appeal decisions both as to his competence and as to the proposed treatment to a court [*elective referral*]. Such a process of elective referral is operative¹⁰⁰ in many European countries and has been described as follows:

... the patient has the right to demand a second opinion by an external MD of choice and has the right to appeal the medical judgment (on incompetence and on the medical procedure) in court (including the right to appeal the court decision to higher court – practices and interpretations differ on when and whether awaiting the court’s decision suspends the medical intervention, with clear cases at both ends of the spectrum (if the intervention is irreversible, it is suspended without doubt; if the intervention is life saving, it is not suspended in the absence of a recent, indisputable, signed and dated written living will refusing that specific intervention in these specific circumstances).¹⁰¹

In making a choice between a process of automatic referral to the courts or one of elective referral, the efficient utilisation of court, legal and medical resources is clearly of importance however, the defence of the rights of the one who it is proposed to subject to coercive treatment, is of paramount importance. The resolution of such questions clearly require further research.

(iii) In relation to coercive psychiatric treatments, the requirement that a proposed treatment does not occasion impairment must be discharged – in all but the most exceptional circumstances – not by means of unalloyed clinical judgement,¹⁰² but on the basis of evidence-based studies.

(iv) The few, limited, analyses that have sought to determine the prevalence of evidence-based psychiatric treatments, have concluded that approximately half of

⁹⁹ In such circumstances the court (much like the subject in the case of consensual treatment) removes from the clinician’s shoulders the responsibility to not cause a harm if that harm was a foreseen possible consequence of the treatment.

¹⁰⁰ Professor Joris Vandenberghe, personal communication.

¹⁰¹ *Ibid.* It is unclear whether such elective referrals should apply to *all* proposed coercive medical treatments such as, for example, the installing an intravenous line by a nurse under medical supervision.

¹⁰² See Chapter 5 where it was concluded that psychiatric assessments of the benefit or detriment of psychiatric treatments which are based solely on clinical judgement, are unreliable.

all psychiatric treatments are evidence-based.

In such reviews, the standard used in assessing a treatment as being evidence-based is the simple existence of randomised experimental studies showing that on balance, the treatment is likely to be beneficial; the soundness of such studies is presumed. The results of such analyses do not permit the estimation of the proportion of psychiatric treatments – (and *a fortiori*) of coercive psychiatric treatments – that may occasion harm.

(v) The influence of the pharmaceutical industry on the nature, conduct and reporting of psychiatric research is pervasive, often hidden, and is of such a magnitude as to cast doubt on the impartiality, objectivity and evidence base of much published research.¹⁰³

(vi) The incontrovertible conclusion to be drawn from the existence of grossly inconsistent results in relation to trials of first and second generation antipsychotics,¹⁰⁴ is that some supposedly evidence-based studies supporting the psychiatric use of antipsychotics, are deeply flawed.¹⁰⁵

(vii) There is a manifest reluctance amongst many clinical psychiatrists to changing their beliefs in relation to the appropriate prescribing of antipsychotics, in the face of authoritative disconfirming evidence relating to their safety and efficacy of atypical antipsychotics.¹⁰⁶

Assessments of dangerousness

(i) There is a widespread belief amongst the general public, that the presence of mental disorder greatly heightens the risk of violence. However, the

¹⁰³ See Appendix J. An indication of the level of untoward influence on academic psychiatry by the pharmaceutical industry, is given in a New York Times editorial on the Harvard psychiatrist Dr. Joseph Biederman which was entitled “*Expert or Shill?*”

Editorial (2008). ‘Expert or Shill?’ *The New York Times*. 30 November.

¹⁰⁴ In that antipsychotics are commonly used in the treatment of schizophrenia which (as discussed earlier) can function as a surrogate for those psychiatric conditions precipitating coercive intervention; the conclusions concerning antipsychotics are of particular relevance to the dissertation argument.

Conclusions concerning antidepressants are given in Appendix K.

¹⁰⁵ See Appendix L and, in particular, Tyrer & Kendall (2009) who in an editorial *The Lancet*, commented that:

... what was seen as an advance 20 years ago ... is now, and only now, seen as a chimera that has passed spectacularly before our eyes before disappearing and leaving puzzlement and many questions in its wake. ...

The spurious invention of the atypicals can now be regarded as invention only, cleverly manipulated by the drug industry for marketing purposes and only now being exposed.

¹⁰⁶ See Appendix L where the author of the Cutlass 1 study [Jones (2007)] recommended that: “*educated clinicians as well as their patients should begin to take into account the results of such trials.*” Urging the importance of trusting the data rather than clinical intuition and drawing on the analogy of his hobby of hill walking, he said:

Sometimes the compass tells you go straight in front of you, but you somehow know it is wrong and that north is behind you,... I have learned to follow the compass.

preponderance of research indicates that – in the absence of substance abuse – the risk of violence is no greater than that occurring in the general population and, furthermore, that substance abuse itself is the best predictor of violent behaviour. There are grounds for contending that, in response to media pressure, many politicians and some eminent psychiatrists, rather than challenging, collude with and thereby reinforce, these public misperceptions.

(ii) Some eminent academic psychiatrists appear either unwilling or unable to appreciate either the high rate of error involved in psychiatric risk assessment or the extremely serious consequences that may befall anyone subjected to such an erroneous assessment of dangerousness.

Stigma

(i) Studies¹⁰⁷ designed to assess the presence amongst psychiatrists of stigmatising and stereotypical attitudes towards their patients have found such attitudes to be as, if not more, prevalent than amongst the general public.

This suggests that the campaigns against psychiatric stigma, led by the psychiatric profession and addressed to general public, may be primarily self-serving.¹⁰⁸

(ii) Campaigns against psychiatric stigma, must be replaced by a rights based perspective¹⁰⁹ which focuses on the penalising of discriminatory behaviour against psychiatric ‘survivors’.¹¹⁰

B.2.2: Proposals: Psychiatry

(i) The lack of reliable, complete data in relation to the use of coercive practices in psychiatry must be urgently addressed; data must include details of the consequences of the use of coercive methods and in particular: the incidence and nature of iatrogenic harm; of psychiatric misdiagnosis and of erroneous assessment of dangerousness.

¹⁰⁷ See Chapter 7 and, in particular the discussion of Nordt (2006) and Clarke & Rowe (2006).

¹⁰⁸ See Chapter 7 and especially Chamberlin (2006).

¹⁰⁹ As has occurred in relation to AIDS sufferers. See also the Report of The National Council on Disability (2000), p.25:

NCD heard numerous eloquent pleas for services that were responsive and respectful, and which allowed recipients the same rights and freedoms other citizens take for granted. It is important to keep in mind that the hearing was one of the rare opportunities for people labeled with psychiatric disabilities themselves to be the major voice in a government-sponsored inquiry into mental health issues. It is common for mental health policy discussions never to mention words such as “involuntariness” or “force,” because these topics are seldom addressed except by people who have suffered because of them.

This reports was entitled ‘*From Privileges to Rights.*’

¹¹⁰ ‘Survivor’ is the self-descriptive term preferred by those ex-patients who campaign against forced psychiatric treatment; see, for example, Emerick (2006).

- (ii) The psychiatric profession must, in its practices, manifest an acknowledgement and acceptance of the likelihood of psychiatric misdiagnosis, iatrogenic harm and erroneous assessments of dangerousness.
- (iii) The psychiatric profession must accept that clinical psychiatrists should be legally liable for the negligent breach of their obligations in the same manner and, to the same extent, as are other medical professionals.
- (iv) Psychiatrists must accept (as have some of their French¹¹¹ and Italian¹¹² colleagues) the use of coercion *necessarily* cause harm and strive to achieve agreement on the choice of psychiatric treatment, by negotiation.
- (v) A reliable evidence base is required for many psychiatric treatments which are in common use.¹¹³
- (vi) It is imperative that research be undertaken into the use of drug-free and minimal drug therapies in the management of psychiatric disorders.¹¹⁴ The

¹¹¹ See, for example, an interview with Dr. Jean Oury of the La Borde clinic in France:

When we see a patient, the ethic, the respect, is not to embarrass him, but to respect the other who is there with his personal problem. This needs a permanent form of phenomenological reduction, a 'bracketing off' of things, ... It works, because at this very moment we are ... within the same landscape of the patient. ... We are not on one side with the patient on the other side.

[online], available: <http://www.gold.ac.uk/media/interview1-jean-oury.pdf> [accessed: 4 July 2011].

¹¹² See, for example, Mordini (1994):

"The health system is required to propose a therapeutic path. If this path starts without the patient's consent, it should be considered a failure of the system" [Norcio (1988)]. The therapeutic path cannot therefore admit compulsory/coercive treatments (other than as a sign of its failure); on the contrary it can obviously conceive negotiated treatments.

The reference is to Norcio B., Pastore V. (1988): Il consenso del malato di mente al trattamento: quali indicazioni per i servizi. In Cendon P. (Ed) *Un altro diritto per il malato di mente*, Napoli, 255-265.

¹¹³ See Appendices K and L.

Although ECT has been regarded by most psychiatrists as the "... *the gold standard for treating severe depression.*" [Goodman (2011)], it has recently come under renewed scrutiny. Read & Bentall (2010), for example, summarise their findings:

Conclusions: Given the strong evidence (summarised here) of persistent and, for some, permanent brain dysfunction, primarily evidenced in the form of retrograde and anterograde amnesia, and the evidence of a slight but significant increased risk of death, the cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified.

An FDA subcommittee on ECT has recommended that it be subjected to rigorous testing as to its safety and efficacy [Brown (2011)]:

The majority of the 18-member committee said not enough is known about ECT, ... to allow the devices to be used without more research into its usefulness and hazards.

... the advisory panel heard FDA staffers describe their analysis of hundreds of ECT studies. As a group, the studies tended to be poorly designed and with too few patients to allow the drawing of firm conclusions. Many failed to follow patients long enough to discover the duration of ill effects.

... Panel member Christopher A. Ross, a psychiatrist and neuroscientist at Johns Hopkins University, asked if the published studies identified any risk factors that predisposed patients to memory loss and thinking impairment. "*Evidence-based data for that issue just doesn't exist,*" said Peter G. Como, a neuropsychologist at the FDA.

Brown, D. (2011). 'FDA panel advises more testing of 'shock-therapy' devices'. *Washington Post*. 28 Jan.

¹¹⁴ See, for example, the judgement in *DPP v B* (2011) concerning the detention of 'B' in the Central Mental Hospital, in Dublin:

influence of pharmaceutical companies in suppressing and distorting the results of drug trials¹¹⁵ adds further emphasis to the need for such treatments, especially in relation to schizophrenia.¹¹⁶

B.3: Conclusions and Proposals: Law¹¹⁷

The not insubstantial possibility that a coercive intervention is precipitated by a psychiatric misdiagnosis or an erroneous assessment of dangerousness, and which will result in a treatment which may have deleterious effects on the health of the subject, cannot find any shelter under the doctrines of paternalism which the courts have often adopted in their reluctance to subject psychiatric coercive psychiatric practices to careful scrutiny.

It is clear that once the possibility of such occurrences is accepted, the courts would be duty bound to defend the rights of anyone who might be subjected to such eventualities and – since such cases cannot be readily identified except by a judicial investigation – to subject *all* coercive psychiatric interventions to a judicial scrutiny.

It is of interest to note that in some of those cases which perchance did fall to be judicially examined, the judicial assessment did not conform to psychiatric assessments as, for example:

- in the Manweiler case¹¹⁸, his psychiatrist had noted “*a serious history of violence.*” Yet on cross examination it became clear that the only evidence for this assertion was that on the evening in question, Manweiler had been “*aggressive in voice*” towards his mother.
- In the Bingley case¹¹⁹, his psychiatrist – who had assessed Bingley as being dangerous and in need of coercive treatment – had justified his assertion on the grounds that: “*He gets up in people’s faces. I think the majority of people would*

[5.14] In the course of her evidence, Dr. Linehan told the Court that since taking over as the defendant’s treating psychiatrist, almost two years ago, she has seen him on fifty-five occasions. Dr. Linehan told the Court that these meetings lasted, on average, fifteen minutes except when a particular assessment of the defendant’s mental state was being undertaken and then the meeting would last longer. On these occasions, up to five other people might be present, and on the other occasions, the numbers would vary.

[5.15] Unfortunately, what is clear from Dr. Linehan’s evidence is that she does not see it as part of her function in this particular case to attempt to enter into a meaningful therapeutic relationship with the defendant.

[Emphasis added]

¹¹⁵ See Appendix J.

¹¹⁶ See Appendix L on non- or minimal drug treatment for schizophrenia.

¹¹⁷ These conclusions and proposals relate to the Irish legal system.

¹¹⁸ See Appendix H.

¹¹⁹ See Chapter 6.

just punch him.”

The court did not accept the psychiatric assessment of dangerousness.

- In the Starson case¹²⁰ the Canadian Supreme Court in rejecting the application of two psychiatrists that Starson be forcibly medicated with neuroleptics, stated that there was no evidence that the proposed medication was likely to ameliorate Professor Starson’s condition and that neuroleptic medication carries with it: “... *significant, and often unpredictable, short term and long term risks of harmful side effects*”.

None of these incongruities would have come to light in the absence of a judicial review.

Another area where the appropriateness of judicial review has been contested is in relation to the Guantanamo Bay cases in the US; these often involve assessments of dangerousness by terrorism ‘experts’ and have seldom been subjected to full judicial scrutiny. In one such case whilst terrorism experts had cited three independent pieces of evidence, the courts had found that these were all repetition of essentially the same piece of evidence; the court stating: “*We are not persuaded. Lewis Carroll notwithstanding, the fact that the government has ‘said it thrice’ does not make an allegation true.*”¹²¹

Again the point may be made that in the absence of a judicial review such evidential deficiencies would not have come to light.

The judicial review of coercive psychiatric interventions cannot be left to such happenchance and – as suggested by Olofsson¹²² – a countervailing force needs to be put in place to scrutinise clinical psychiatric practice especially when the use of coercion is envisaged. It was concluded (*supra*) that a rights based approach is the only mechanism likely to be effective in combating psychiatric stigma; such an approach clearly requires the close involvement of the legal system and its mechanisms of judicial review.

B.3.1: Conclusions: Law

- (i) The unwillingness of the courts to actively scrutinise the coercive psychiatric interventions, on the grounds of their supposedly paternalistic nature is insupportable; this is manifestly evident when the possibility of a coercive

¹²⁰ See Chapter 5.

¹²¹ *Parhat, Huzaifa v Gates, Robert* (2006).

¹²² See Introduction.

intervention grounded in a psychiatric misdiagnosis or erroneous assessment of dangerousness, and resulting in iatrogenic harm, is taken into account.

(ii) In view of the fact that deprivation of liberty and coercive treatment are *prima facie* harmful, there is no justification for the current practice of interpreting the rules and legislation governing coercive psychiatric interventions, as being other than mandatory.

B.3.2: Proposals: Law

(i) All coercive psychiatric interventions, whether of detention or of treatment, must be reviewed by a court at the earliest opportunity; a maximum period of seven days is suggested.

Mindful of the fact that many psychiatrists have been shown to be overconfident in their diagnostic skills and unreliable in their predictions of the benefits and detriments of psychiatric treatment, it is necessary that the court ‘descend into the arena’ and actively scrutinise the evidence on which psychiatrists purport to base their opinions. If necessary, a court-appointed psychiatrist or psychologist could assist in such a scrutiny.

(ii) It is necessary that those who believe that they have been harmed as a result of a psychiatric intervention, are afforded unfettered access to the courts subject only to the usual rules in relation to vexatious litigation.

(iii) The court must rigorously distinguish between an application for a coercive psychiatric intervention based on a subject’s supposed ‘best interests’ and one based on his supposed ‘dangerousness to others’.

(iv) Bearing in mind that the primary obligation placed on a nation’s courts is to defend the personhood of its citizens, courts should be mindful of the fact that, in assessing an application based on a subject’s supposed ‘best interests’, such interventions have, on occasion, been shown to have had such catastrophic consequences that they have resulted in the destruction or diminution of a subject’s personhood.

Recognising that the use of coercion is itself damaging, every effort should be made to find non-coercive alternatives.

(v) The standard of proof required for a committal on the grounds of dangerousness to others should be the same as for a criminal conviction *i.e.* of the order of 10:1.

(vi) The courts should be mindful of the fact that psychiatrists have been shown to be unreliable in their assessments of dangerousness. Accordingly, in assessing an application based on a subject's supposed dangerousness, a coercive intervention should only be permitted if it can be shown that others who manifest an equal or greater level of dangerousness (*e.g.* by reason of alcohol or drug use) are subjected to a comparable level of coercive intervention.

The implementation of any such test poses particular difficulties and the establishment of a monitoring system is required so as to enable an ongoing audit of those detained on the grounds of their dangerousness, in order to determine whether the number of those detained on psychiatric grounds, when compared with the number of those detained on other grounds, corresponds to the independently determined, actual level of risk posed by the differing groups.¹²³

(vii) In view of the fact that the prolonged use of psychoactive drugs as a mechanism of restraint (whether or not described as 'treatment') may be considerably more invidious than physical restraint in that it trespasses on the psyche of the subject; the courts, whilst they may permit coercive psychiatric intervention (*e.g.* detention or restraint) in the interests of others, should be loath to sanction the coercive administration of psychoactive drugs (other than for purposes of short term, emergency restraint) under the guise of a psychiatric 'treatment'.

¹²³ Lest such a proposal appear unworkable, a not dissimilar system is used in determining whether security services rely on 'racial profiling' (*i.e.* the targeting of particular racial minorities as being more likely to be involved in particular types of criminality) in the exercise of their discretionary powers. See, for example, Dodd (2011) who in a report of a court proceedings, noted the use of the argument that:
... a disproportionate number of black Londoners are searched in violation of article 14 of the European convention on human rights ... statistical evidence implies that a black person is more than nine times more likely to be searched than a white person.
Dodd, V. (2011). 'Racist' stop-and-search powers to be challenged.' *The Guardian*. 8 July.

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A philosophical investigation into coercive
psychiatric practices

2 Volumes

Gerald Roche MSc, MPhil, BCL, BL.

Volume 2 of 2

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Appendix A: Some relevant sections of the Irish Mental Health Acts

Provisions of the *Mental Treatment Act* (1945) which have been referred to in the main body of the dissertation are given in full in *Section I*; those of the *Mental Health Act* (2001) are given in *Section II*.

Section I: The Mental Treatment Act (1945)

Commencement of proceedings by patients or ex-patients

Time limit on certain proceedings.

259.—Proceedings by a person who has been detained in a mental institution and has ceased to be so detained and which are in respect of an act purporting to have been done in pursuance of this Act shall not be instituted after the expiration of six months after the cesser of the detention.

Leave of the High Court for certain proceedings.

260.—(1) No civil proceedings shall be instituted in respect of an act purporting to have been done in pursuance of this Act save by leave of the High Court and such leave shall not be granted unless the High Court is satisfied that there are substantial grounds for contending that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care.

(2) Notice of an application for leave of the High Court under sub-section (1) of this section shall be given to the person against whom it is proposed to institute the proceedings and such person shall be entitled to be heard against the application.

(3) Where proceedings are, by leave granted in pursuance of sub-section (1) of this section, instituted in respect of an act purporting to have been done in pursuance of this Act, the Court shall not determine the proceedings in favour of the plaintiff unless it is satisfied that the defendant acted in bad faith or without reasonable care.

(4) Where, on an application under sub-section (1) of this section, leave is given to bring any proceedings and the proceedings are commenced within four weeks after the date on which leave was so given, the proceedings shall, for the purposes of section 259 of this Act and of the Public Authorities Protection Act, 1893, be deemed to have been commenced on the date on which notice of the application was given to the person against whom the proceedings are to be brought.

Section II: The Mental Health Act (2001)

'Mental disorder'

3.—(1) In this Act “mental disorder” means mental illness, severe dementia or significant intellectual disability where —

(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or

(b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her

condition or would prevent the administration of appropriate treatment that could be given only by such admission, and
(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

(2) In subsection (1) —

“mental illness” means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons; ...

Criteria for involuntary admission to approved centres.

8.—(1) A person may be involuntarily admitted to an approved centre pursuant to an application under *section 9 or 12* and detained there on the grounds that he or she is suffering from a mental disorder.

(2) Nothing in *subsection (1)* shall be construed as authorising the involuntary admission of a person to an approved centre by reason only of the fact that the person —

- (a) is suffering from a personality disorder,
- (b) is socially deviant, or
- (c) is addicted to drugs or intoxicants.

Best interests of person

4.—(1) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.

(2) Where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person, under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make representations in relation to it and before deciding the matter due consideration shall be given to any representations duly made under this subsection.

(3) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

Power to prevent voluntary patient from leaving approved centre.

23.—(1) Where a person (other than a child) who is being treated in an approved centre as a voluntary patient indicates at any time that he or she wishes to leave the approved centre, then, if a consultant psychiatrist, registered medical practitioner or registered nurse on the staff of the approved centre is of opinion that the person is suffering from a mental disorder, he or she may detain the person for a period not exceeding 24 hours or such shorter period as may be prescribed, beginning at the time aforesaid. ...

Treatment not requiring consent

57.—(1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.

(2) This section shall not apply to the treatment specified in section 58, 59 or 60.¹

Referral of admission order and renewal order to a tribunal

17.—(1) Following the receipt by the Commission² of a copy of an admission order or a renewal order, the Commission shall, as soon as possible —

(a) refer the matter to a tribunal³,

(b) assign a legal representative to represent the patient concerned unless he or she proposes to engage one,

(c) direct in writing (referred to in this section as “a direction”) a member of the panel of consultant psychiatrists established under section 33 (3)(b) to — (i) examine the patient concerned,

(ii) interview the consultant psychiatrist responsible for the care and treatment of the patient, and

(iii) review the records relating to the patient,

in order to determine in the interest of the patient whether the patient is suffering from a mental disorder and to report in writing within 14 days on the results of the examination, interview and review to the tribunal to which the matter has been referred and to provide a copy of the report to the legal representative of the patient. ...

Review by a tribunal of admission orders and renewal orders.

18.—(1) Where an admission order or a renewal order has been referred to a tribunal under section 17, the tribunal shall review the detention of the patient concerned and shall either —

(a) if satisfied that the patient is suffering from a mental disorder, and

(i) that the provisions of sections 9, 10, 12, 14, 15 and 16, where applicable, have been complied with, or

(ii) if there has been a failure to comply with any such provision, that the failure does not affect the substance of the order and does not cause an injustice, affirm the order, or

(b) if not so satisfied, revoke the order and direct that the patient be discharged from the approved centre concerned.

(2) A decision under subsection (1) shall be made as soon as may be but not later than 21 days after the making of the admission order concerned or, as the case may be, the renewal order concerned. ...

¹ S. 58. concerns psycho-surgery; S. 59, electro-convulsive therapy [ECT] and S.60, the administration of medicine.

² The Mental Health Commission is established under S. 32 of the Act.

³ Under S. 48 of the Act, the Mental Health Commission is given power to establish Mental Health Tribunals.

Leave of High Court for certain proceedings.

73.—(1) No civil proceedings shall be instituted in respect of an act purporting to have been done in pursuance of this Act save by leave of the High Court and such leave shall not be refused unless the High Court is satisfied:

(a) that the proceedings are frivolous or vexatious, or

(b) that there are no reasonable grounds for contending that the person against whom the proceedings are brought acted in bad faith or without reasonable care.

(2) Notice of an application for leave of the High Court under subsection (1) shall be given to the person against whom it is proposed to institute the proceedings and such person shall be entitled to be heard against the application.

(3) Where proceedings are, by leave granted in pursuance of subsection (1) of this section, instituted in respect of an act purporting to have been done in pursuance of this Act, the Court shall not determine the proceedings in favour of the plaintiff unless it is satisfied that the defendant acted in bad faith or without reasonable care.

Appendix B: Coercive, non-psychiatric, medical interventions

A number of coercive, non-psychiatric, medical interventions are discussed in this appendix: the coercive use of caesarean sections is discussed in *Subsection B-1*; the forcible detention and treatment of tuberculosis sufferers is discussed in *Subsection B-2* and the use of compulsory preventive medication is discussed in *Subsection B-3*.

B-1: Forced Caesarean Sections

Since the 1980s, some US State courts have, on occasion, granted orders compelling a woman to submit to a caesarean section; these orders were, in the main, sought by obstetricians as a preemptive defence against possible liability in the event of injury to the foetus.¹

The first application² to an English court for such an order was made in 1992; it concerned a mother who refused, on religious grounds, to submit to a caesarean section. The court declared that the operation, being vital to the protection of the interests of the patient and her unborn child, was lawful.³ This decision was criticised by the Royal College Of Obstetricians and Gynaecologists firstly, because the judgement "... [elevated] the status of the fetus in law to such an extent that its supposed rights become more important than its mother's."⁴ but, more importantly, because similar decisions might immeasurably damage the doctor-patient relationship and drive away those in greatest need of help.⁵ This argument is of particular interest in that it is similar to that put forward by some psychiatrists and civil libertarians in arguing against the practice of coercive psychiatry.

Though the decision in *Re S* was also widely criticised by legal experts, similar decisions followed at an ever increasing rate.⁶ These cases were reviewed by the Court of Appeal in 1996⁷ and it laid down the general principle that a competent woman has an absolute right to refuse medical intervention even where that decision might lead to her death or the death of the foetus.

¹ Royal College of Obstetricians and Gynaecologists (1996), S 2.1.

² *Re S (Adult: refusal of medical treatment)* [1992].

³ Wilson & Smith (1995) have argued that:

[it is unclear] whether the declaration was ordered upon the basis of protecting the incipient interests of the unborn child alone or in tandem with those of the mother. If the former, it might be difficult to insulate such decisions from authorising other coerced medical interventions, for example, a kidney 'donation' on an unwilling relative, or even mother! (p.395)

⁴ Royal College of Obstetricians and Gynaecologists (1996), S. 3.8.9.

⁵ *Ibid.* S. 3.9.2.

⁶ At the rate of over one a month during 1996; see Goldbeck-Wood (1997).

⁷ *Re MB (Caesarean Section)* (1997).

Some subsequent court applications have sought to use the protection afforded by the UK Mental Health Acts to circumvent the Court of Appeal ruling. In one such case a pregnant woman, X, on visiting her GP was told that she had pre-eclampsia⁸. He advised immediate hospitalisation which she refused. He then contacted a social worker who arranged that X, who had had no previous history of mental disorder, be committed to hospital under the Mental Health Acts and an application was made to the High Court to proceed with a caesarean section without the knowledge of X or her legal advisers.⁹ In subsequent proceedings taken by X the Court of Appeal ruled that her admission to a mental hospital was unlawful and entitled her to substantial damages for false imprisonment and for being forced to undergo treatment against her will.¹⁰

Because of the constitutional protection afforded to the unborn under the Irish Constitution, the Irish courts are unlikely to follow the English precedents limiting coercive caesarean section in that these were based on the view that, before birth, the foetus has no defensible right as against its mother.¹¹ In view of newspaper reports¹² of threats, by a Dublin hospital, of legal proceedings against a woman who refused to have a caesarean section, the question is likely to come before the Irish courts in the foreseeable future.

Before leaving this topic, there is a final point which is of importance in assessing the question of *'for whose sake'* the intervention is being made. This concerns the additional risk placed on the woman by being subjected to a caesarean section, and the point was made by the chairman of the American Medical Association's Council on Ethical and Judicial Affairs in speaking against the practice of forced caesarean sections:

It is a fundamental ethical and legal principle that patients cannot be forced to accept a risk to health to benefit another, whether the other is a person or a foetus. ... The risk of death for the pregnant woman from a caesarean section is two to four times higher than that from a vaginal delivery.¹³

This issue finds a parallel in the assessment of, and the weight that should be accorded to, any additional health risks attendant on forced psychiatric treatment undertaken on the grounds of perceived dangerousness to others.

⁸ Pre-eclampsia is a hypertensive disease which is a major cause of maternal and foetal morbidity and mortality.

⁹ Dyer (1998a).

¹⁰ Dyer (1998b).

¹¹ Royal College Of Obstetricians and Gynaecologists (1996), S. 5.3: "*Although obligations to the fetus in utero increase as it develops, UK law does not grant it personal legal status. This comes from the moment of birth.*"

¹² The Sunday Times (2005). 'Mother threatened with forced caesarean'. *The Sunday Times*. 24 April.

¹³ Dyer (1994).

B-2: Forcible Intervention Against Tuberculosis Sufferers

Tuberculosis (TB) is a contagious disease which presents a serious threat to world health; it currently infects one third of the world's population and kills approximately 2 million individuals annually.¹⁴ Due to some patients not fully completing their course of treatment, new drug resistant strains of the disease have emerged which are difficult and expensive to treat.¹⁵

The legal situation in the UK in relation to detention and compulsory treatment of persons suffering from TB is set out in the *Code of Practice of the British Thoracic Society*:

Compulsory treatment is not allowed but in exceptional circumstances it may be necessary to consider compulsory admission of a patient who is causing serious risk of infection to others. ... Clearly this is not the kind of action to be undertaken lightly as it involves depriving someone of his or her liberty. ... If the person has to be detained it will be necessary to obtain a magistrate's order for admission ... and another order for detention.¹⁶

During 2005, a number of news stories appeared in the British media highlighting the danger of drug resistant TB and the inability of the health authorities to ensure that patients completed their treatment programmes. The manner of reporting amounted to a campaign in favour of introducing compulsory treatment for TB. One newspaper, for example, under the heading '*TB human timebomb infects 12*'¹⁷ reported that a convicted criminal with a highly contagious form of tuberculosis had infected at least 12 people because the authorities were powerless to make him accept medical treatment. It claimed that doctors were "*furiously*" that legislation had not been enacted to enable compulsory treatment and it reported a consultant with the Government's Health Protection Agency as stating that "*the biggest problem with TB is that we cannot compulsorily treat people*". The article quoted a Government spokesperson as stating that a review of Britain's public health laws was being considered but that human rights legislation might prevent imposing compulsory treatment orders.

The Guardian, under the heading '*Law lets TB patient infect 12 others – No one can be forced to take treatment*'¹⁸ carried essentially the same story but added:

But the idea that an individual can knowingly be infectious and retain his anonymity due to rules on patient confidentiality is potentially politically

¹⁴ DeAngelis & Flanagan (2005).

¹⁵ It has been reported that medication normally costs \$11 per patient whereas treatment of the drug resistant strain can cost up to \$250,000 per patient; see The Irish Times. (1996). 'WHO Warns of Global TB Disaster'. *The Irish Times*. 22 March.

¹⁶ Joint Tuberculosis Committee of the British Thoracic Society (2000), p.888.

¹⁷ The Mail on Sunday. (2005). 'TB human timebomb infects 12'. *The Mail on Sunday*. 8 May.

¹⁸ The Guardian. (2005). '*Law lets TB patient infect 12 others - No one can be forced to take treatment*', *The Guardian*. 9 May.

explosive. Seven in 10 people with the disease come from an ethnic minority and two-thirds were born abroad.

The same story was again carried by the BBC online news story but with a gloss: a Professor Peter Davies, secretary of the charity TB Alert, was quoted as stating: “*To insist on compulsory treatment would be a step too far. Forced treatment would be just horrendous.*”¹⁹ In that Professor Davies is one of the leading experts on the treatment of TB²⁰, it seems that coercive treatment might not be the ‘obvious solution’ that many considered it to be.

A parallel may be drawn between the depictions of TB and mental illness in the popular media where mental illness is often viewed through the narrow and distorting prism of dangerousness; as a consequence, ideas of mental illness and dangerousness are often conflated in the public mind.²¹ The link between dangerousness and mental illness is the subject of Chapter 6 of the dissertation but it may be of assistance in the disentangling of these ideas to, at this stage, briefly examine the academic response to media demands for coercive treatment of individuals with TB.

An editorial in the *British Medical Journal*²² described how, in response to an epidemic of TB in the early 1990s, New York City instituted a successful programme of eradication by adopting a twin track approach: investing in model treatment programmes but also by relying on a coercive strategy. Prior to this, coercion had been invoked only if the individual posed a serious risk to the health of others (a risk-assessment strategy); the New York programme, however, permitted coercion in respect of non-infectious individuals who were adjudged unlikely to fully complete a treatment programme (a non-compliance strategy). More than 200 non-infectious patients were detained under this provision, some for over two years. The editorial argues against the employment of such coercive strategies:

Before detention is resorted to, practical (and cheaper) alternatives should be available. If an order for detention is sought then details of attempts at less

¹⁹ BBC (2005). ‘Care refusal spread TB to others’ *BBC News* [online], available: <http://news.bbc.co.uk/2/hi/health/4528543.stm> [accessed: 21 August 2006].

²⁰ According to the *British Medical Journal*, Professor Davies:

... set up, and is now Director of the Tuberculosis Research and Resources Unit. In 2004 he was appointed Honorary Professor to Liverpool University. Professor Davies has written extensively. He edited *Clinical Tuberculosis*, the only definitive reference work on tuberculosis published outside the USA.

[Online], available: <http://www.bmjmasterclasses.com/respiratory/speakers> [accessed: 20 April 2006].

²¹ Such public perceptions, even if erroneous, create a momentum and actuality of their own and lead to the development of government policies designed to assuage, rather than correct, these perceptions; this, in the view of many commentators was what motivated the (English) *Mental Health Bill 2004* which has now been withdrawn following strong criticism by a coalition of civil libertarians and the psychiatric profession. The Royal College of Psychiatrists (2004), for example, argued that: “*the proposed legislation is extremely unlikely to have any impact on suicide or homicide rates.*”

²² Coker (1999b).

restrictive alternatives should be presented to the magistrate. Moreover, an explicit objective examination of the potential threat posed by each non-compliant individual should be made and legal representation made available for those at whom the order is directed.²³

The editorial – which anticipates that, as happened in New York, media campaigns in the UK will call for the detention of non-compliant individuals – urges that “*Both civil rights and public health can be protected, but the emphasis should be on resource and organisational requirements, rather than coercion.*”²⁴

Writing in response to this editorial, a correspondent described how in Australia, even though legislation had provided for the coercive treatment of TB:

... in over eight years, not a single order has led to a patient with tuberculosis being imprisoned. ... over 4000 cases have been effectively managed in the community. ... Rather than investing in a good public health system and well resourced community based services, the United States seems to be using ‘deprivation of liberty’ to solve not only its social problems but also its tuberculosis epidemic. This is an abuse of human rights and makes no sense in terms of public health.²⁵

An editorial²⁶ in the journal *Thorax*, in discussing the New York campaign, emphasised the importance of distinguishing between the perception of risk and the actual risk posed by an individual with TB. Whereas the perception of risk, fuelled by media, was that all New Yorkers were at risk, the reality was quite different.

... those using homeless shelters in which beds were spaced 18 inches apart and HIV prevalence was high were obviously at greater risk of exposure than those in the leafy suburbs. But the perception was high in New York that all were at risk, and undoubtedly encouraged the response seen.²⁷

This emphasis on assuaging the perception of risk rather than estimating the actual risk led even civil libertarian critics to ignore:

... the actual magnitude of the threat posed by non-infectious poorly compliant individuals, particularly by those opposing the regulatory changes. The Health Department officials simply suggested that “*over time, it is likely that they (poorly compliant, non-infectious individuals) will pose a very serious threat to large segments of the public.*”²⁸

The editorial concluded that:

An approach to our understanding of risk with regard to tuberculosis must therefore attempt to define the risk of an event occurring (for example, the transmission of tuberculosis from a smear negative poorly compliant individual), determine the gravity of that event, weight different available measures to be taken, and alter the perception of risk with time both as our understanding

²³ *Ibid.* p.1435.

²⁴ *Ibid.*

²⁵ Levy & Alperstein (1999).

²⁶ Coker (1999a).

²⁷ *Ibid.* p.96.

²⁸ *Ibid.* p.95.

improves and as circumstances change. ... The global control of tuberculosis may be harmed more than it is assisted by inappropriate, ill judged, culturally insensitive coercive public health measures.²⁹

Aside from the US, the international consensus³⁰ on TB control appears not to favour coercive public health measures – a position reemphasised in a recent *British Medical Journal* editorial.³¹

The parallel between coercive intervention in relation to TB and coercive psychiatric interventions was noted in a submission made by The Royal College of Psychiatrists to the (UK) Joint Committee on the Draft Mental Health Bill:

Nonetheless there are a small number of mentally disordered people who present serious risks to others. ... the central issue is what degree of certainty should be required before determining that such a person is dangerous. For example if a person suffering from tuberculosis, or other notifiable infectious disease, refuses treatment they will only be detained if the form of TB makes it almost inevitable that other people will become infected. Any lesser standard in relation to the mentally disordered would be inappropriate. Clinically this is particularly difficult to determine, hence, for example, the estimation that, with current knowledge and skills, between 2000 and 5000 people would need to be detained to prevent one homicide ...³²

Adding further emphasis to its views on coercive psychiatry, the College prefaced its submission with a quotation:

The whole picture (on the provision of care and treatment) is distorted by the use or prospect of compulsion, which deters people from seeking treatment, denies them the right to choose the treatment they want, and prioritises certain kinds of patient in the offer of services.³³

A case concerning the compulsory detention in relation to TB came before the Irish courts in 2008.³⁴ The applicant who had, some years earlier, been treated for TB in South African, was suspected of suffering from TB when she became ill in Ireland. She refused treatment and was detained under the S.38 of the *Health Act* (1947) but had been assessed by psychiatrists as competent. She had been detained for over a year and began *habeas corpus* proceedings seeking her release. It transpired that though the *Health Act* (1947) provides for detention and segregation it does not provide for compulsory treatment.

²⁹ *Ibid.* p.96.

³⁰ Coker (1999a), p.96; Ribeiro (2003).

³¹ Maher (2003).

³² Royal College Of Psychiatrists (2004), p.17-8.

³³ *Ibid.* p.1, quoting Baroness Hale of Richmond, Sieghart lecture, British Institute of Human Rights 2004.

³⁴ See O'Connell, B. (2008). 'Court action over TB woman's year-long forced hospitalisation.' *The Irish Times*. 6 November.

B-3: Compulsory Preventive Medication

Even the most cursory outline of this topic is far beyond the scope of this appendix; my purpose in adverting to it is to draw attention to the existence of occasions when, in a non-psychiatric setting, preventive medication is made compulsory. By 'preventative medication' in this context, I mean medication given to an individual for a condition from which he presently does not suffer, but for which he is considered to be at risk.

The discussion is restricted to developments in the UK and Ireland as these are the areas of most relevance to the argument being developed in this dissertation.

Compulsory vaccination was first attempted in the UK in 1853 when smallpox vaccination was made mandatory for infants. In reaction, an anti-vaccination movement was quickly established whose political influence grew to such an extent that by 1889 a Royal Commission was appointed to find more acceptable methods of resolving the problem. Their report in 1898 was something of a compromise in that it recommended that, whilst compulsion should remain, any parent who could satisfy magistrates that they conscientiously believed that vaccination would be harmful to their child, was excused. Even this was not acceptable to the anti-vaccinationists (who included such eminences as George Bernard Shaw) and in 1907 a new Act was passed which allowed parents to obtain exemption by simply attesting to their honestly held belief that vaccination was not in the best interests of their child; within a few years this resulted in 25 per cent of newborns avoiding vaccination. The resistance to vaccination arose not only because it was believed to carry risk (some believed it to cause leprosy) but also because it contravened deeply held beliefs about the integrity of the body. The attempt at compulsion can be viewed as a struggle between, on the one hand, the protection of the common good and, on the other, the safeguarding of the rights of the individual, and – in that smallpox is a highly infectious disease – the interest of the body politic was no mere theoretical one, yet individualism triumphed over the common social interests.³⁵ Although the political struggle over compulsory smallpox vaccination occurred over a hundred years ago it seems that public attitudes in the UK have changed but little in the intervening period as is evidenced by the depth of emotion engendered by the introduction of the (non-mandatory) MMR vaccine.

The issue of compulsory mass medication became a topic of controversy in Ireland in 1960 with the introduction of legislation permitting the fluoridation of the public water

³⁵ In writing this section, I have relied heavily on Pedersen (2005) and Dalrymple (2006).

supply. The constitutionality of this legislation was challenged in *Ryan v AG* (1965) which is one of the most important cases in Irish Constitutional Law in that it established that the personal rights of citizens were not limited to those enumerated in the constitution but included unspecified rights such as the right to bodily integrity. The plaintiff argued that the process of fluoridating water not only amounted to ‘mass medication’ (and that the state had no power to administer drugs in such a fashion)³⁶ but was also a source of danger to the public. The court held that even if it was agreed that fluoridation was dangerous (a position that it did not accept) the plaintiff’s case failed because:

The plaintiff has no legal right to a supply of piped water and the Act of 1960 does not impose any obligation on her ... to drink or use the water coming through the piped water supply. ... Moreover, ... [the plaintiff] can, by the expenditure of a few pounds, remove all or almost all the fluoride ions coming through the piped water supply.³⁷

There has been continuing controversy in Ireland over the use of fluoridation with some arguing that it increased the risk of childhood bone cancer.³⁸ In response to such concerns, the Irish government established a ‘Forum on Fluoridation’ whose report³⁹ in 2002 recommended that fluoridation should continue but with a decrease in the permissible level of fluoride. In an appendix to the report, Professor Binchy examined the developments in Irish Constitutional Law since the Ryan case with a view to determining whether a new constitutional challenge to mass fluoridation might be decided differently. He argued that if mass fluoridation were to be regarded by the courts as a form of mass medication then, in so far as there is a right to refuse medical treatment,; “ ... *it is hard to see how there is nonetheless an obligation to submit to legislatively authorised State action that constitutes medical treatment.*”⁴⁰ He considered such an interpretation unlikely.

The question of compulsory vaccination came before the Irish courts in *North Western Health Board v HW and CW* (2000) where the Health Board sought an injunction to compel the parents to consent to a PKU test⁴¹ on their child. The parents had refused consent on the grounds that the test was invasive. The court refused to grant the injunction holding that (other than in exceptional circumstances) parents were entitled to make these decisions even if, as it believed in the instant case, they made the

³⁶ *Ibid.* at p.345.

³⁷ *Ibid.* at p.314.

³⁸ The Irish Independent. (2006). ‘*Dentists warn of flouride water dangers*’. *The Irish Independent*. 8 April.

³⁹ Department of Health and Children (2002).

⁴⁰ *Ibid.* p.222.

⁴¹ This is a test for disability which requires the taking of a blood sample.

wrong decision. The judgement noted that the State did not seek to use compulsion in relation to the inoculation and vaccination of children where the case for compulsion was far stronger than in respect of the PKU test.

The riposte made in the Ryan case (that there is no obligation on anyone to use the medicated supply and that non-medicated alternatives can easily be obtained) is likely to be used as a defence against any possible criticism of recent proposals⁴² to add folic acid to bread in an attempt to reduce the number of cases of infants born with spina bifida. The agency anticipated “ ... *general ethical population concerns about prospect of ‘compulsory’ or ‘mass medication’ issues.*”⁴³

A practice of administering preventive psychiatric medication has been recently adopted in the US in relation to young people who have not, as yet, developed schizophrenia but who are believed to be susceptible to developing it later in life. Although the results of a recent study using antipsychotics were less than impressive – they were summarised by one of the lead authors in the words: “*The positive result was only marginally significant, and the negative result was clear.*”⁴⁴ – they have not lessened the enthusiasm for future trials. Though such medication is not mandatory at present, it may become so in view of proposals by the US administration for the mass screening of schoolchildren for susceptibility to mental illness.⁴⁵

⁴² As advocated by The Food Standards Agency in the UK. Similar proposal have recently been made in Ireland; Donnellan E. (2006). ‘Body calls for use of folic acid in bread’. *The Irish Times*. 18 July.

⁴³ The Times. (2006). ‘Folic acid in bread to cut birth defects’. *The Times*. 5 April; *The Independent*. (2006). ‘Add folic acid to bread’ to tackle birth defects’. *The Independent*. 5 April.

⁴⁴ The New York Times. (2006). ‘Mixed Result in Treating Schizophrenia Pre-Diagnosis’. *The New York Times*. 1 May.

⁴⁵ Lenzer (2004).

The American Psychiatric Association, in their July 2004, Advocacy News took some credit for keeping this story out of the American news: “*The BMJ story has gained some traction in derivative reports on the Internet, though mainstream media have not touched the story, in part thanks to APA’s work, for which the administration is appreciative.*” [Online], available: http://www.psych.org/join_apa/mb/newsletters/advocacy/AdvNewsJuly2004.htm#21 [accessed: 3 May 2006.].

Appendix C: The Amy case: conflicting perspectives

The details of this case are set out in Chapter 2.¹ The focus of this appendix is on the conflicting testimony of Dr. Cameron who was Amy's hospital physician [*Subsection C-1*], Dr. Watler [*Subsection C-2*] and Dr. Gervais [*Subsection C-3*] who were her psychiatrists and Dr. Cameron's response to the psychiatric testimony [*Subsection C-4*]. *Subsection C-5* contains some observations on the case and *Subsection C-6* draws some conclusions.

*C-1: Cameron (hospital physician)*²

The person I encountered was a petite, bright and charming woman who came across as younger than her 77 years. She exuded a vivacity, a determination to make the most of every moment, but hinted that she was aware of the bad news the biopsy might bring. During her history and physical she regaled me with a long, rambling monologue. Her garrulousness didn't strike me as at all unusual. Many people deal with anxiety by talking, and Amy was evidently concerned about the biopsy.

- *on her haematologist:*

... found her to be “*an alert and intelligent lady*” ... “*She has an excellent understanding of this disease and has decided not to have any treatment.*”

- *on her psychiatrist:*

For him, her habit of speaking tangentially was evidence of mental illness. He recorded inconsistencies in her behaviour, such as reporting “*intense pain*” while refusing to take analgesics. ... the psychiatrist raised the issue of paranoid ideation and said that psychosis could not be ruled out. He ... suggested that Amy be certified ...

- *on her attending physician:*

... was convinced that Amy was competent. ... He conferred with Amy's family physician; both agreed that, as difficult as the situation was, Amy had the right to take her own life. ... [he] felt that her actions were rational: she had a value system and had made a decision consistent with her beliefs. He also noted wryly that the current test of rationality was often concurrence with the opinions of one's physician.

- *on her social worker:*

... expressed concern that Amy appeared mentally ill. She felt that she was “*... unstable, paranoid and grandiose ... not rational.*”

- *on legal considerations:*

Curiously, there was little consideration of the legal implications. No one suggested that a lawyer's opinion be sought. ... Any concerns we might have had about legal liability were pushed aside by the debate about the patient's interests.

¹ See Subsection A.

² All text in the body of Subsections C-1 to C-4 are direct quotations from Cameron (1997a), Watler (1997), Gervais(1997) and Cameron (1997b) respectively.

- on autonomy:

The decision to let Amy leave hospital was not a black-and-white issue. ... Amy didn't have to die; her death lacked the inevitability that accompanies terminal illness. I didn't feel that she was mentally ill in the clinical sense. Her decision to die was, to me, not the defeated wish of a depressed person, but an affirmative act to conclude her life on her own terms. ... As I grappled with this ambivalence, I kept returning to one theme, one certainty. I was confident that we had respected Amy's rights. She died the way she wanted to, with her dignity intact. ... I think Amy taught me that it is imperative to respect the autonomy of the people we care for even if we disagree with their reasoning.

C-2: *Watler (psychiatrist)*

- on mental disorder (generally):

There is no evidence that patients with serious medical illnesses '*rationally*' choose to die. ...

There is common belief that the forensic term '*mental disorder*' is synonymous with psychiatric classification or '*clinical*' conventions. ... Mental disorder is, in fact, very poorly defined in the various mental health acts, and this omission is quite deliberate. The physician need not establish an '*identifiable psychiatric illness*' as a requirement for involuntary committal. Rather, persons should be detained for evaluation when there is high-risk behaviour and evidence to suggest any form of mental disorder. The brevity of this detention — a maximum of 7 days in Nova Scotia — does not represent a significant deprivation of freedom.

- on mental disorder (Amy):

What evidence was there to suggest that Amy was suffering from a mental disorder?

- Months before, she had refused a life-saving intervention with a high therapeutic index.

- Her speech and writing demonstrated significant thought-form disorder.

- There was psychomotor agitation, irritability and lability³ of mood.

- There was social withdrawal and suspiciousness.

It seems speculative to conclude that Amy was not mentally ill in the '*clinical*' sense or, more important, in the forensic sense.

With recent suicidal behaviour and evidence to suggest a mental disorder, the law requires that an unwilling patient be involuntarily committed. That Amy's clinicians could not agree on the presence of a mental disorder is precisely the reason for detaining high-risk patients for further evaluation.

C-3: *Gervais (psychiatrist)*

- on Amy's refusal of treatment:

There is no doubt that the patient's rights, such as refusing treatment, must be respected. Nevertheless, one should look into this refusal and its meaning, ... She was an intelligent, articulate person who talked in an apparently logical way and was listened to in a similar logical way, but she was certainly not listened to with the '*third ear*.'

³ "*Emotionally or behaviourally unstable*." Shorter Oxford Dictionary (1997).

- on Amy's psychiatric symptoms:

In psychiatric terms, this woman was showing signs of grandiosity: she was called “*The Queen*” in her neighbourhood and she would not let nature or fate or destiny or God take her life. Instead, she would be the one who decided when to live and when to die, and in a way she would act like God. This, to me, is manic denial.

C-4: Cameron's response

I find it illuminating that most people who knew this woman superficially, whether from reading about her or after a single consultation, felt that she was mentally ill. By contrast, those who came to know her well over time, who had established a relationship with her, were convinced she was eccentric but competent.

I reject Watler's assertion that anyone refusing treatment with a ‘*high therapeutic index*’ must be mentally ill. ... People who refuse blood transfusions for religious reasons are not mentally ill, even when their decision does not seem rational when measured against our values.

C-5: Some observations on the Amy case

I wish to make a number of observations on the Amy Case under some specific headings:

(i) Consent

Dr. Gervais argues to the effect that even though Amy stated that she did not want any psychiatric intervention, she ‘really’ did and this would have been obvious had she been listened to with the “*third ear*”. To imagine this argument being made by one charged with rape, is sufficient to demonstrate its folly; furthermore to argue that, against clear evidence to the contrary, one's belief can be justified by listening with one's ‘third ear’ is – if not itself delusional in the clinical sense⁴ – sufficient to immunise any delusion against rational argument.

(ii) 'Facts'

Dr. Watler proceeds to draw conclusions from what he believes to be established facts amongst which are: “*Her speech and writing demonstrated significant thought-form disorder*”; “*There was psychomotor agitation, irritability and lability of mood*”, yet which seem curiously at odds with Cameron's description: “*Her garrulousness didn't strike me as at all unusual. Many people deal with anxiety by talking*”.

(iii) Mental Illness

Watler draws a distinction between suffering from mental disorder and being diagnosed with a specific psychiatric illness.

⁴ *Vide* Chapter 3 and the clinical definition of delusion.

This distinction is capable of two interpretations, a narrow and a broad: the narrow interpretation would be that the individual who has a mental disorder, has – because of difficulty in carrying out a differential diagnosis – not yet been diagnosed as suffering from a *specific* psychiatric illness. A similar such situation might occur in a non-psychiatric medical setting, when a patient is suffering from a fever but it is not clear yet whether he is suffering from a malarial or some other fever. The broad interpretation is when it is possible that an individual might suffer from a ‘mental disorder’ and not suffer from *any* identifiable psychiatric illness. It is clearly this broad sense that Watler has in mind when he says:

Mental disorder is, in fact, very poorly defined in the various mental health acts, and this omission is quite deliberate. The physician need not establish an ‘*identifiable psychiatric illness*’ as a requirement for involuntary committal. Rather, persons should be detained for evaluation where there is high-risk behaviour and evidence to suggest any form of mental disorder.

This poses grave difficulties for any analysis of misdiagnosis in psychiatry for not only does the term ‘misdiagnosis’ cover a diagnosis which was not made in accordance with the specific diagnostic criteria for the various psychiatric disease categories as specified in the standard diagnostic manuals – such as the ICD-10 and the DSM-IV – but it also covers those who were never believed to suffer from an identifiable psychiatric illness but who have been wrongly diagnosed as having ‘mental disorder’.

This distinction is discussed further in Chapter 4.

(iv) *Default presumptions relating to coercive psychiatric interventions*

When presented with a recalcitrant individual for psychiatric evaluation, Watler’s ‘default position’ is to urge involuntary committal for evaluative purposes; he states: “*It seems speculative to conclude that Amy was not mentally ill*”. Transposed to the criminal law, this principle would read: ‘*It seems speculative to conclude that the accused is not guilty*’ whereas the relevant legal principle actually is ‘*If a reasonable doubt exists as to the guilt of the accused, he should go free*’.

Such a stark contrast between psychiatric and legal principles seems difficult to justify unless one believes that coercive psychiatric intervention is essentially benign and this appears to be Watler’s position: “*The brevity of this detention – a maximum of 7 days in Nova Scotia – does not represent a significant deprivation of freedom.*” It was argued earlier that, in some circumstances, a coercive psychiatric intervention might be compared to a rape because of the intimacy of its intrusiveness. If this comparison is well-founded, then arguments as to the brevity of the detention are comparable to a rapist seeking to mitigate his crime by arguing that the rape lasted but a short time.

(v) Irrationality

The term ‘irrationality’ is not mentioned explicitly in the discussion, whereas the terms ‘not rational’ and ‘rational’ do occur: Cameron describes one such use by Amy’s attending physician who “... *felt that her actions were rational: she had a value system and had made a decision consistent with her beliefs;*” Watler considers the refusal of treatment with a high therapeutic index to be “*not rational*”. The contrast between these two positions highlights the difficulty in determining the meaning to be accorded to these terms when used in a psychiatric setting.

(vi) Psychiatric Labels

The usage of psychiatric labels⁵ –

“manic denial” ... “signs of grandiosity” ... “significant thought-form disorder” ... “psychomotor agitation, irritability and lability of mood” ... “social withdrawal and suspiciousness” ... “unstable, paranoid and grandiose ... not rational” ... “paranoid ideation” ... “psychosis could not be ruled out”,

– is so pervasive as to be promiscuous and as if the terms were benign; it shows little awareness of the potency of these terms and of the serious consequences that may flow from their inappropriate use.

C-6: Conclusions

Although the Amy case is but a single case of psychiatric intervention on the grounds of irrationality, it is a particularly powerful example in that the psychiatrists involved must be assumed (in responding to an article in a medical journal which was critical of their professional expertise and judgement) to have carefully considered their reply and drafted it in a manner which would meet with the approval of their professional colleagues. Unless the Amy case is truly exceptional, the (tentative) conclusion may be drawn that the psychiatric usage of terms such as ‘irrational’ is so lacking in precision and awareness of the detrimental consequences of their ascription, as to merit the description ‘cavalier’.

⁵ The labels which follow, were applied to Amy by various professionals and are direct quotations from either Cameron (1997a), Watler (1997), Gervais(1997) or Cameron (1997b).

Appendix D: Estimates of the rate of marital infidelity

The goal of this appendix is to see whether it is possible to estimate the probability that the wives of individuals in circumstances such as Blehein's¹ or Fulford's Mr. O.S.² – *i.e.* jealous husbands in unhappy marriages who believe their wives to have been unfaithful – actually have been unfaithful.

Some general statistics are given in *Subsection D-1*; some more particular estimates are given in *Subsection D-2* and some conclusions are drawn in *Subsection D-3*.

D-1: Some general statistics on rates of infidelity

Hargrave (2000) whilst noting the difficulties involved in estimating rates of marital infidelity, summarises some studies:

Kinsey (1953) ... estimated that 50% of husbands and 26% of wives engage in at least one extramarital affair³ ... Glass and Wright (1992) put the estimates at 44% for men and 25% for women. ... So it is probably realistic to assume that the rate of infidelity is somewhere between 30% and 55% for men and between 25% and 40% for women.⁴

UK studies give comparable estimates:

- A 1949 survey (the results of which were withheld at the time)⁵ found that 20% of women admitted to having had an extra-marital affair.
- A 2005 study by the counselling service *Relate* found that 24% of wives admit to having had affairs.⁶

D-2: Some more particular statistics on rates of infidelity

More nuanced estimates are available where, for example, the sample population is restricted to couples who describe themselves as 'unhappy' or where a husband exhibits jealousy or where a husband believes that his wife has had an affair.

Unhappy marriages

The Kinsey Institute quotes⁷ a study in relation to 'unhappy' couples:

Respondents who reported that their relationships were "pretty happy" and "not too happy" were two and four times more likely, respectively, to have reported

¹ See Chapter 3.

² *Ibid.*

³ A 1991 update to the Kinsey study found a rate of 31% [see University of Berkley, Department of Statistics, (2006)].

⁴ Hargrave (2000), p.165.

⁵ Sussex University, Press release, 'Sussex archive reveals secret sex lives of 1940s Britain'. [online], available:http://www.sussex.ac.uk/press_office/media/media505.shtml [accessed 5 July 2006].

⁶ The Sunday Times (2005) 'Secret Passions of the Grey 1940's'. 4 September.

⁷ The Kinsey Institute. 'Frequently asked sexuality questions to The Kinsey Institute' [online], available: <http://www.kinseyinstitute.org/resources/FAQ.html#Laumann> [accessed: 10 August 2006].

extramarital sex than respondents who reported that they were “*very happy*” with their relationships [Atkins (2001)].

Jealous husbands

A US study examined the effect of a husband’s jealousy on the wife’s propensity to have an extramarital affair:

Women who complained that their husbands are jealous and possessive reported a higher probability that they will have brief affairs with other men. ... Although causality cannot be inferred from these correlational data, the pattern does suggest that the husbands’ displays of jealousy and possessiveness may veridically reflect a higher likelihood of their partners’ infidelity, especially in the form of a brief affair.⁸

Suspicious husbands

Andrews (2008) sought to determine the reliability of a partner’s belief in the unfaithfulness of their spouse. Men who reckoned that the probability that their wives had had an affair exceeded 50%, were classified as ‘suspicious’; the study concluded that the likelihood that the beliefs of such suspicious husbands, was correct, was 69.2%.⁹ Hence, given that a husband is ‘suspicious’, it is 2.3 times more probable that his wife was unfaithful, than that she was not.

D-3: Conclusions

Taking 25% as a tentative estimate of the extent of female marital infidelity and restricting the discussion to marriages where the husband was jealous and the couple were “*not too happy*”, a tentative estimate¹⁰ of the probability that the wife was unfaithful exceeds 50%, *i.e.* it is more likely than not that the wife of a jealous husband in an unhappy marriage has had, or will have, an extramarital affair. The presence of jealousy on the husband’s part would, according to Buss (1997) increase the probability of wife being unfaithful. The suspicion that she was having an affair would, according to Andrews (2008), increase the probability to 70%.

⁸ Buss & Shackelford (1997), p.213.

⁹ Data abstracted from Andrews (2008), Table 3, p.353.

¹⁰ Talking a sample of 84 couples [84 is chosen to avoid the occurrence of fractions] and assuming that an equal number of couples were “*very happy*”, “*pretty happy*” and “*not too happy*”, then assuming that 25% of wives (*i.e.* 21) were unfaithful [Atkins (2001) *supra*]:

- 3 would be in marriages described as “*very happy*”
- 6 would be in marriages described as “*pretty happy*”
- 12 would be in marriages described as “*not too happy*”

Thus the probability that the wife was unfaithful in a marriage described as “*not too happy*” would be 12/21 = 57%.

More formally, the following conclusion can be drawn:

In marriages which were described as 'unhappy' and where the husband exhibited jealousy, a tentative estimate of the probability that the wife was unfaithful, exceeds 50%. A tentative estimate of the likelihood of the correctness of a 'suspicious' husband's belief that his wife is unfaithful, is 70%.

In attempting to apply such results to cases such as Blehein's, the objection might well be made that the spouses studied by, for example, Andrews (2008) were not reported as exhibiting any evidence of mental illness. To this, it can be countered that in cases such as Blehein's, the *only*¹¹ evidence of mental illness in cases of delusions of infidelity, is often just the supposed 'delusion'.

A further point of interest arising from Andrews (2008) is that those 'suspicious' husbands who believed their wives to be having an affair were unable to justify this belief (in the sense discussed in Chapter 3) but based their belief on hunches or 'guesses'; their doing so did not appear to raise the spectre of mental illness (*pace* the psychiatric analysis of such cases as discussed in Chapter 3).

¹¹ See Enoch (1967) (*supra*):

I have now in an asylum two quite rational-looking men, whose chief delusion is that their wives, both women of undoubted good character, had been unfaithful to them. Keep them off that subject and they are rational. But on that subject they are utterly delusional and insane. (p. 47)

Appendix E: Prevalence of unjustifiable beliefs amongst ‘normal’ subjects

As discussed in Chapter 3, one who cleaves, unshakably, to a belief (other than a religious belief) without being able to justify it, can be clinically diagnosed as ‘delusional’; implicit is the presumption that such beliefs do not occur amongst the ‘normal’¹ population. The goal of this appendix is to examine the prevalence of such tenaciously held, unjustifiable, beliefs amongst the general population [*Subsection E-1*], amongst some academic or professional subgroups [*Subsection E-2*] and to draw some conclusions [*Subsection E-3*].

E-1: Unjustifiable beliefs in the general population

Some US studies are first examined and then some UK studies.

United States

A Harris (2003) survey into the beliefs of Americans, found that:

Many people believe in miracles (84%), the devil (68%), hell (69%), ghosts (51%), astrology (31%) and reincarnation (27%). ... The 84% of the public who believe in miracles falls to 72% among those with postgraduate degrees, and rises to 90% among women and 90% among African-Americans.

A Gallup (2005) poll found that three in four Americans held paranormal beliefs in at least one of the following:

... extra sensory perception (ESP), haunted houses, ghosts, mental telepathy, clairvoyance, astrology, communicating with the dead, witches, reincarnation, and channeling. There are no significant differences in belief by age, gender, education, or region of the country.

United Kingdom

A 1998 survey² to determine the prevalence of paranormal beliefs found that 47% believed in thought reading (14 % having had direct experience) and 34% believed that objects can be moved by the power of the mind (4% having had direct experience).

A Mori (2003) survey found that:

... 40% now said they believed in ghosts, and 15% that they had “personal experience” of ghosts; 6% of the public, indeed, said they had based a decision on their belief in ghosts. ... 18% of the public said they believed in fortune telling or tarot, and 38% in astrology.

¹ The ambiguities inherent in the term ‘normal’ are discussed in Chapter 3.

² *Daily Mail* (1998) ‘Survey of Britons’ 2 Feb. Copy available online: <http://www.uri-geller.com/survey1.htm> [accessed 31 July 2006].

E-2: Examples of unjustifiable beliefs amongst the professions

Lest it be thought that the professions and academia might be inured from such unjustifiable beliefs, I wish to mention a 2007 survey of the beliefs of university students and then two particular examples: the first concerns the beliefs of a Harvard professor, in alien abduction; the second concerns the beliefs of UK social workers, in the prevalence of the ‘satanic abuse’.

Student survey

This study examined the beliefs of 800 German university students of psychology, philosophy and science and was published in *Philosophy, Psychiatry & Psychology*; it found, *inter alia*:

That extrasensory perception and telepathy may occur is assumed by 64% of the students, incidences of miraculous mental healing by 45%, the validity of horoscopes by 17%, and the use of exorcism under extreme circumstances by 14% ...³

Alien Abduction

Mack was professor of psychiatry and wrote extensively on alien abduction⁴. He believed that:

... “aliens” from higher space-time dimensions are visiting Earth, and that this “*Phenomenon is occurring in the context of the threat to the earth as a living system, a response to the ecological devastation that our particular species has undertaken.*” The aliens are engaged in what he called a “*cosmic correction*”; they appear to function “*as a kind of intermediary between the Source of creation and us, emissaries perhaps of that correction.*”⁵

Satanic Abuse

This example is of interest in relation to the evidential base that supposedly normal professionals use to ground their beliefs.

Satanic abuse, as described in the *British Medical Journal*:

... seemed to have reached epidemic proportions in a small part of the north east of England. The paediatricians and social workers seemed to be zealots – children who turned up at hospital with minor unrelated symptoms were diagnosed as having been sexually abused, with reflex anal dilatation as the sole criterion, and were taken into care.⁶

One of the most controversial interventions occurred in Rochdale where, without warning, police and social workers took 16 children into care for what was to be a total of 34 years and four months.⁷ It was alleged they had been forced into devil worship

³ Fahrenberg & Cheetham (2007), p 190.

⁴ Mack (1994) is a sympathetic study of such cases.

⁵ *The (London) Independent*, (2004) ‘Obituaries John E. Mack’, 8 Oct.

⁶ Essex (1997).

⁷ BBC News (2006). ‘Lost years of ‘satanic panic’ children’. *BBC*. 11 January. [online], available: http://news.bbc.co.uk/2/hi/programmes/real_story/4602302.stm [accessed 1 Aug 2006].

and had been sexually abused. The event that precipitated the intervention was the experience of one boy who appeared to be unduly fearful and who often spoke about ghosts, which (to the social workers involved) was his way of referring to sexual abusers. Yet there was never any proof – forensic, medical or otherwise – to support claims of ritual abuse against any of the families. When police raided the house they took as ‘evidence’ a cross made by one child from two lollipop sticks and a religious wall plaque that she had given her mother, portraying Jesus on the Cross, which bore the words “*God bless our home*” and featured a small well for holy water. It was later alleged that this had been used to hold blood.⁸

None of these allegations were upheld by the courts.

Subsequently the British Government appointed Jean La Fontaine (an anthropologist) to head an investigation, she found that:

... to those for whom the status of the accuser allowed of no doubt, evidence was irrelevant, although there was faith that it would be forthcoming. To show scepticism was to be accused of supporting paedophiles; to try and explain was seen as an attempt to excuse. The claim that satanic abuse was the cause of serious psychic damage to children and adults was a moral judgement, not a rational argument from the facts.

It is this belief in unverified and unverifiable mystical evil that, *par excellence*, classes belief in satanic abuse with belief in witchcraft whether in the European distant past or in the recent past ...⁹

One point of especial interest, in the context of coercive psychiatric interventions, is that the judge in the Rochdale case, did accept that the social workers were motivated by zeal rather than by malice: “*I do not question the good faith or good intentions of the social workers, who I acknowledge were working under considerable pressure.*”¹⁰ Such a defence would¹¹ exonerate psychiatrists (unlike social workers) from civil liability for a coercive intervention based on similarly unjustifiable grounds.

E-3: Conclusions

I wish to avoid, what biologist Richard Dawkins calls, the “*Argument from Personal Incredulity*”¹² and simply conclude, not that all the above beliefs are untrue, but that the psychiatric perception of the beliefs of normal subjects – especially the perception that normal people are able to justify their beliefs – is not possible to sustain in the face of such evidence.

⁸ The Times (2006). ‘Our stolen childhood’ *The Times*. 10 January.

⁹ La Fontaine (1998), p.185.

¹⁰ *The Times* (2006). ‘Our stolen childhood’ *supra*.

¹¹ See the *Mental Health Act* (2001), S. 73.

¹² *I.e.* that if it seems impossible to me, it must not be true; see Dawkins (1995), p 29.

Appendix F: Problematic aspects of psychiatric probability assessments

The importance of the role played by probability assessments in medical decision making¹ is most clearly manifest when the consequences of an erroneous probability assessment become apparent; the criminal conviction in the Sally Clark case [*Subsection F-1*] provides a striking example. The Clark conviction was overturned because the medical expert based his testimony on explicit data and a probability calculation both of which were provably incorrect.

Much more insidious are ‘intuitive’ probability assessments made in response to an inadequately formulated problem and which are made in the absence of explicit data (e.g. psychiatric assessments as to what is ‘normal’); it is extremely difficult to mount a direct challenge to any such assessments in the absence of explicit data especially since ‘intuitive’ judgements have a natural affinity with ‘common-sense’ perceptions; accordingly it is important to emphasise the often radical difference between a probability assessment which has been rigorously calculated, and one based on intuition – a phenomenon encapsulated in the description of probability assessments as often being ‘*counter-intuitive*’; examples are given in *Subsection F-2*. Intuitive probability assessments underlie many psychiatric diagnoses either explicitly (as in the definition of delusion²) or implicitly (as in the assessment that a particular behaviour or belief is not ‘normal’); many such intuitive psychiatric assessments will be shown³ to be erroneous; in consequence many psychiatric assessments of what is pathological (assuming the pathological and the normal to be mutually exclusive categories) are also necessarily erroneous.

Theoretically more complex errors – the so-called ‘*Base Rate*’⁴ errors – feature prominently in the mis-interpretation of test results whether in general medical practice (e.g. mammography) [*Subsection F-3*] or in clinical psychiatry (e.g. assessments of dangerousness) [*Subsection F-4*]. The presence of such errors is pervasive in the psychiatric literature on dangerousness,⁵ moreover the errors are of such a magnitude [*c.*

¹ Sutherland (1992), for example, states: “*Whether doctors acknowledge it or not, most medical diagnosis relies on probabilities, ...*” (p. 176).

² Sedler (1995), p.256: “*Bizarre delusions are generally impossible, whereas nonbizarre delusions are generally improbable.*”

³ *Infra* and Chapters 3 and 6.

⁴ Also known as ‘*Conditional Probability*’ or ‘*Bayesian Analysis*’.

⁵ See Chapter 6 for an extended discussion.

ten-fold]⁶ as to render such assessments not only deeply flawed but, in themselves, parlous – an ironic conclusion in that some psychiatrists believe that the cause of some psychiatric illnesses lies in an inability to make correct probability assessments.⁷ Conclusions are listed at the end of subsections *F-2* and *F-4*.

F-1: The Sally Clark case

In 1999 a solicitor, Sally Clark, was convicted of smothering one baby son and of shaking her other son to death. Her conviction hinged on expert evidence given by an eminent paediatrician Professor Sir Roy Meadow who estimated the likelihood of two infants from the same family dying of SIDS⁸, as one in 73 million.

The Royal Statistical Society took the unprecedented step of writing to the Lord Chancellor to register its objection to the way the statistic had been calculated,⁹ and stated that:

... a medical expert witness drew on published studies to obtain a figure for the frequency of sudden infant death syndrome ... He went on to square this figure to obtain a value of 1 in 73 million for the frequency of two cases of SIDS in such a family. This approach is, in general, statistically invalid ...
Aside from its invalidity, figures such as the 1 in 73 million are very easily misinterpreted. Some press reports at the time stated that this was the chance that the deaths of Sally Clark's two children were accidental. This (mis-)interpretation is a serious error of logic known as the '*Prosecutor's Fallacy*'.¹⁰

Clark's conviction was subsequently quashed.¹¹

A number of points arising from this case are of interest in the present context:

- Meadow's probabilistic estimates were not based on intuition but on published data, furthermore he used (albeit inappropriately) accepted mathematical techniques. Thus both the data and the calculation were open to external scrutiny and rebuttal.

The statement of the Royal Statistical Society¹² emphasised the severe consequences that could flow from erroneous probability assessments. The

⁶ See, for example, Szmukler (2001a) *infra*.

⁷ See *infra* and Blankenburg (2001), p.308.

⁸ Sudden Infant Death Syndrome.

⁹ BBC News, (2003). 'On This Day:2003: Solicitor cleared of killing sons' *BBC News* [online], available: http://news.bbc.co.uk/onthisday/hi/dates/stories/january/29/newsid_3412000/3412647.stm [accessed: 7 August 2006].

¹⁰ The Royal Statistical Society (2001); the '*Prosecutor's Fallacy*' is discussed in F-III (*infra*).

¹¹ BBC News, (2003) (*supra*).

¹² The Royal Statistical Society (2001):

Society does not tolerate doctors making serious clinical errors because it is widely understood that such errors could mean the difference between life and death. The case of R v Sally Clark is one example of a medical expert witness making a serious statistical error, one which may have had a profound effect on the outcome of the case.

consequence that might follow from an erroneous psychiatric probability assessment based on clinical intuition are no less severe in that they may equally result in wrongful incarceration but, lacking an explicit evidence base (as was used by Meadow) they would not be open to the independent scrutiny of bodies such as the Royal Statistical Society; in the absence of explicit statistical evidence to the contrary, such probability assessments would be effectively immune from review.¹³

- The true probability of a double cot death (in excess of 1 in 214)¹⁴ would, when viewed from the perspective of intuitive probability, be regarded as highly improbable and as providing no reason to set the verdict aside; it exemplifies the falsity of the intuitive nostrum (*infra*): “*that the extremely low probability of an event happening is evidence that it has not happened.*”

Because of the absence of ‘raw data’, many probability judgements that arise in the course of psychiatric clinical practice are not amenable to a mathematical analysis¹⁵ and are thus wholly reliant on intuition (‘clinical judgement’). It is relatively easy to correct intuitive probability assessments when they can be compared with mathematical probability assessments based on the agreed data; however, in the absence of such data, the evidence would suggest that intuitive probability assessments should be treated with extreme caution. In such circumstances Montaigne’s advice is apposite: “... *there is a silly arrogance in continuing to disdain something and to condemn it as false just because it seems unlikely to us.*”¹⁶

As will be shown in the following section, Montaigne’s advice is well founded.

F-2: The Counterintuitive Nature Of Some Probability assessments

The counterintuitive nature of probability assessments will be shown by:

- taking some common intuitive probability assessments which can be shown to be erroneous, [F-2(i)]
- outlining some research on the unreliability of intuitive probabilistic reasoning, [F-2(ii)]

¹³ See the discussion in Chapter 6 on psychiatric assessments of dangerousness.

¹⁴ The author of the original study stated that:

... although his study contained the one in 73 million figure, it was “*somewhat unreliable*” because of the “*extreme rarity*” of double cot deaths. “*It was never intended as a real statistical estimate,*” he told the hearing. The true rate could range between 1 in 214 and 1 in 8,500.

Laurance, J. (2006) ‘Child abuse expert ‘used statistics out of context’ at cot death trial’. *The Independent*. 24 June.

¹⁵ See, for example, the discussion in Chapter 3 on the phenomenon of ‘hearing voices’.

¹⁶ de Montaigne (1991), p.200.

- considering some seemingly commonsensical – but nonetheless unsustainable – statements concerning probability which are implicit in many ‘common sense’ type arguments and which are also to be found in some academic writings on psychiatry.¹⁷ [F-2(iii)]

F-2(i): Examples of counterintuitive probability assessments

I will give three examples.

(a) The longest record for a run on black in a game of roulette occurred in a Monte Carlo casino in 1913 when the ball landed on black a record twenty-six times in succession. Amongst watching gamblers this precipitated:

... a near-panicky rush to bet on red, beginning about the time black had come up a phenomenal fifteen times ... players doubled and tripled their stakes (believing) that there was not a chance in a million of another repeat. In the end the unusual run enriched the Casino by some millions of francs.¹⁸

The error (known as ‘*The Gambler’s Fallacy*’) is based on a failure to understand statistical independence. Two events are statistically independent when the occurrence of one has no statistical effect upon the occurrence of the other; in playing roulette the occurrence of black has no effect on the colour to occur on the next throw of the ball. A similar error is involved when a coin thrower believes that after he has tossed three Heads in succession, Tails is more likely.

(b) The second example concerns the (unjustified) belief that in a family of six children the outcome BBBGGG¹⁹ is more likely because it appears to better represent the ‘typical’ member of the distribution than GGGGGG which seems ‘unusual’ and hence less probable. This exemplifies the so-called ‘*Representative Bias*’ which occurs when thinking is overly influenced by what is stereotypically true; in the psychology of decision making it is known as the ‘*representativeness heuristic*’²⁰ and is responsible for many cases of misdiagnosis.²¹

¹⁷ E.g. Blankenburg (2001) *infra*.

¹⁸ Huff & Geis (1959), p.28.

¹⁹ B= Boy; G= Girl.

²⁰ Klein (2005):

Kahneman and Tversky showed this heuristic in a classic experiment in which they presented participants with descriptions of people who came from a fictitious group of 30 engineers and 70 lawyers (or *vice versa*). The participants then rated the probability that the person described was an engineer. Their judgments were much more affected by the extent to which the description corresponded to the stereotype of an engineer (for example, "*Jack is conservative and careful*") than by base rate information (only 30% were engineers), showing that representativeness had a greater effect on the judgments than did knowledge of the probabilities.

²¹ Bornstein & Emler (2001):

This “representativeness” heuristic frequently yields accurate results because representativeness often correlates with likelihood. Unfortunately, it also leads people to overweight highly representative individuating evidence and to undervalue relevant prior probabilities. Positive test

(c) In an attempt to emphasize “*how simple intuition can be misleading*”, Holt & Anderson (1996) cite:

... the (true) story about a man who received a positive outcome on a first-stage test for the virus that causes AIDS. The test that was used had a 4% rate of false positives and, for simplicity, it is assumed that there were virtually no false negatives. The person committed suicide before follow-up examinations, presumably not realising that the low incidence of the virus in the male population (about 1 in 250 at that time) resulted in a *posterior* probability of having the virus of only 10%.²²

This provides an example of a typical ‘base-rate’ error [see F-III *infra*].

F-2(ii): Some research on the unreliability of intuitive reasoning

Tversky & Kahneman (1983) examined the lack of congruence between intuitive and formal (*i.e.* mathematical) probability assessments. Their research had lead them to hypothesize that intuitive probability assessments are often made on what is intuitively perceived as being a representative instance rather than on truly probabilistic considerations; they sought to test this hypothesis by asking subjects which of two propositions ‘A’ and ‘A and B’ are more probable.²³ They asked practising physicians to make intuitive predictions on the basis of clinical evidence and found that:

The incidence of violations of the conjunction rule in direct tests ranged from 73% to 100%, with an average of 91%. Evidently substantive expertise does not displace representativeness and does not prevent conjunction errors. ... Most participants appeared surprised and dismayed to have made an elementary error of reasoning.²⁴

F-2(iii): Intuitively correct, but erroneous, probability statements

I have chosen three statements which are, I suggest, intuitively plausible yet are in fact, erroneous:

- (a) that the extremely low probability of an event happening is evidence that it has not happened;
- (b) that estimates of probability point to what is true and that it is irrational to believe in other than the most probable outcome;

results are especially salient in this respect and difficult to ignore, leading doctors in many cases to overestimate the probability of disease. For example, a positive mammogram is perceived as so indicative of breast cancer that it may lead doctors to ignore the relevant base rate — such as that women in a certain age group, without other symptoms, have a very low prior probability of breast cancer — and hence to overweight the import of the positive test result. (p. 99.)

Tversky & Kahneman (1983) proposed that the use of the representativeness heuristic is one of the main causes of base rate errors.

²² Holt & Anderson (1996), at p.179.

²³ Irrespective of content, ‘A’ must always be more probable than ‘A and B’ since every occurrence of ‘A and B’ is necessarily an occurrence of ‘A’.

²⁴ Tversky & Kahneman (1983), p.301-2.

- (c) that probabilistic estimates are objective and thus if estimates conflict, one must be erroneous.

F-2(iii)(a): The extremely low probability of an event happening is evidence that it has not happened

A simple thought experiment is sufficient to dispel this belief: imagine one tosses a box of matchsticks into the air and that one carefully notes the precise position and orientation of each of the fallen matches and the relationship it bears towards its adjoining matches. Had one calculated – before tossing the matches in the air – the chance that this particular ‘aggregate orientation’ (out of all possible aggregate orientations) would happen, then its probability would have been miniscule.

A similar error is pointed out by Blackburn when he notes the fallacy inherent in arguing that because “... *much statistical research argues that since X has a low probability of being caused by chance therefore X is caused by ---.*”²⁵

F-2(iii)(b): Estimates of probability point to what is true and to how the future will unfold

The use of probability measures in relation to the unfolding of events is an indication of the existence of a state of ignorance in relation to the true mechanism, or cause, of the unfolding. Probability, unlike entropy, does not function as ‘time’s arrow’; determinations of the most probable outcome do not point unequivocally to the true or to how the future will unfold.²⁶

The error being discussed appears to be not uncommon even within the philosophy of psychiatry: Blankenburg (2001), for example, seeks to interpret psychiatric illness – and, in particular, schizophrenia – as a deficiency in common sense and, in furthering his arguments, argues for the proposition that the probable provides the basis for what is true:

²⁵ Blackburn (1999), p.224.

²⁶ A thought experiment which took an existing complex situation and which asked whether it had evolved along the path of the most probable outcome, should be sufficient to dispel overestimations of the role of probability assessments.

The noted biologist Stephen Jay Gould died in 2002; twenty years earlier he had been diagnosed with mesothelioma and had been told that “*mesothelioma is incurable, with a median mortality of only eight months.*” He posed the question [Gould (1985)]:

What does ‘median mortality of eight months’ signify in our vernacular? I suspect that most people, without training in statistics, would read such a statement as “*I will probably be dead in eight months*”.

He described his intellectual reaction:

... fine, half the people will live longer; now what are my chances of being in that half. ... I immediately recognized that the distribution of variation about the eight-month median would almost surely be what statisticians call “right skewed.”

In the event, Gould lived for another 17 years – a telling reminder of the limitations of probability assessments especially those based on intuition.

As far as judgement is concerned, it is less a matter of differentiating true from false than of distinguishing the probable from the improbable. Vico had emphasized that just as science is concerned with the truth, so common sense is concerned with the probable (verisimile). It is precisely those errors and derailments at the beginning of the hebephrenic psychoses that make evident for us the fact that the significance of the probable is in no way a deficient mode of cognition of what is true. Rather, the probable is encompassing and provides the basis for what is true, which is here meant in the sense of what is correct and demonstrable.²⁷ [Emphasis added]

When Blankenburg uses the term ‘common sense’ he is using it as meaning that sense which is common or shared within a society as is evident when he states that:

... it is not uncommon for the relatives of the patient to report that the illness began with the patient raising questions about “*the most ordinary things*”. These are things, which, to the common sense of the healthy person, are the most obvious, naturally understood things in life. In contrast, the patients still manage to solve difficult, intellectually more demanding tasks without considerable effort.²⁸ [Emphasis added]

Blankenburg is not alone amongst philosophers in seeking to elevate the status of ‘common sense’ to that of incontrovertible truth; a tendency of which Papineau is highly critical:

Any amount of nonsense was once part of common sense, and much nonsense no doubt still is. It was once absolutely obvious that the heavens revolve around the earth each day, that the heart is the seat of the soul, that without religion there can be no morality, ...²⁹

When common sense can, on principle, be elevated by philosophy and be buttressed by coercive psychiatry, then the danger of a militant orthodoxy being able to exert an intellectual hegemony, becomes real; the cases of Soviet dissidents³⁰ provide a stark warning of the possible dangers.

F-2(iii)(c): Probabilistic estimates are objective and thus if estimates conflict, one must be erroneous.

Building on the analysis of the previous section it is clear that probabilistic estimates are objective – and thus command acceptance – if, and only if, the data on which they are based is explicit and is accepted, by all parties, as being the appropriate basis of calculation.³¹ In particular, intuitive probability assessments are not objective and

²⁷ Blankenburg (2001), p.308.

²⁸ *Ibid.* p.306.

²⁹ Papineau (2006) see also Chapter 2.

³⁰ See Chapters 2, 3 and 4.

³¹ Jaynes (1994) emphasises this point:

Perhaps this makes clearer the reason for our seemingly fanatical insistence on indicating the prior information ‘I’ explicitly in every formal probability symbol $P(A | BI)$. Those who fail to do this may be able to get along without disaster for a while, ... But eventually they are sure to find themselves writing nonsense, ...

cannot command assent. Such probability assessments are estimates – more correctly, ‘hunches’ – based on ‘information’ which may be long forgotten and inaccessible to conscious scrutiny; accordingly they may conflict without either party being necessarily ‘wrong’. The psychiatric testimony given during the trial of Zacarias Moussaoui,³² provides an example of the subjectivity of some psychiatric probabilistic assessments. During Moussaoui’s trial, his defence team sought to establish that he was mentally ill and they introduced a number of psychiatrists to so testify; the prosecution introduced psychiatric evidence in rebuttal.³³

Dr. First, a psychiatrist and editor of the DSM-IV, was one of the defence witnesses. First told the court that Moussaoui suffered from paranoid and grandiose delusions one of which was that he would be freed by President Bush; he testified that:

Moussaoui’s most persistent grandiose belief, First said, is that President Bush will free him from jail, perhaps as part of a prisoner exchange with al Qaeda. Moussaoui also believes he could be of value to the United States, First said, because his testimony could “*clear up September 11 in 15 minutes.*”³⁴

In order to argue that this belief is delusional it is first necessary to establish its falsity;³⁵ the nature of Moussaoui’s belief rendered this impossible and First argued that the belief was so highly improbable as to be false.³⁶ But such probabilistic estimates are a highly subjective exercise and manifest little other than the particular and limited background of the one who makes these estimates: the estimate made by a WASP academic as whether the President of the USA might pardon a Muslim terrorist is likely to be radically different to that made by a disaffected young Muslim.³⁷ The point was well made by the psychiatrist for the prosecution:

³² *USA v Zacarias Moussaoui* (2002); Moussaoui was charged with withholding information in relation to the September 11th 2001 attacks on the US.

³³ The clash of psychiatric testimony is relevant to the validity and consistency of psychiatric diagnosis; see Chapter 4.

³⁴ Hirschhorn, P. (2006) ‘Defense experts call Moussaoui schizophrenic.’ *CNN News* [online], available: <http://www.cnn.com/2006/LAW/04/19/moussaoui.trial/index.html> [accessed: 17 August 2006].

³⁵ See the discussion of delusion in Chapter 3 where it is noted that clinical psychiatrists often replace the ‘falsity criterion’ by a ‘justifiability criterion’.

³⁶ Arthur & Elsibai (2006):

Dr. Michael First, a psychiatrist at Columbia University, told a federal jury that Moussaoui is preoccupied with delusions such as his belief that President Bush will free him.

“*It is so completely implausible on the face of it that it qualifies as a false belief,*” First said yesterday.

Arthur, B & Elsibai, N. (2006) ‘New defense testimony given on Moussaoui mental state.’ *The Boston Globe*, 20 April [online], available: http://www.boston.com/news/nation/articles/2006/04/20/new_defense_testimony_given_on_moussaoui_mental_state/ [accessed: 17 August 2006]

³⁷ It might be argued that the DSM-IV requirement that, to be delusional, a belief “... *is not one ordinarily accepted by other members of the person’s culture or subculture*”, would make this distinction unnecessary. It would have fallen to the prosecution to make the argument that Moussaoui’s belief was accepted in his subculture; and whilst it seems this argument was made, it was not substantiated: “*Dr.*

On cross-examination, Patterson refused to concede that Moussaoui's belief he will be freed is irrational, saying it is plausible that Moussaoui could be freed as part of a hostage exchange. "*I know we traded arms for hostages,*" Patterson said, referring to the Reagan-era Iran-Contra scandal.³⁸

The disparity between the beliefs of Muslims in the UK and the wider UK population was highlighted by some research³⁹ which suggest that intuitive assessments made by an American psychiatrist, of the prevalence of beliefs such as held by Moussaoui – being, as he is, a French Muslim of Algerian extraction and thus closer to fellow Europeans than to Americans – are singularly unlikely to accord with the actual prevalence of such beliefs.

The conclusion that I wish to draw from the above discussion is that psychiatric assessments of the improbability, or of the pervasiveness, of beliefs should be treated with considerable scepticism unless they can be shown to be grounded in reliable statistical data.

F-3: Base Rate errors in general medical diagnosis

Before discussing base rate errors it is crucially important that the following two statements be distinguished:

- the probability that A is true, given that B is the case;⁴⁰ and
- the probability that B is true, given that A is the case.⁴¹

For example, the probability that a man, who was born in Ireland (B), speaks English (A) is radically different from the probability that a man who speaks English (A), was born in Ireland (B).⁴²

The main source of errors occurring in medical and psychiatric probability assessments⁴³ is occasioned by the ignoring of relevant base rates.⁴⁴ In the present

Patterson does not elucidate in his report how he determined other persons of Mr. Moussaoui's subculture would act or believe as Mr. Moussaoui does in Mr. Moussaoui's situation."

[See *USA v Zacarias Moussaoui, Reply To Government's Position On Competency*].

³⁸ Barakat, M. (2006). 'Testimony Concludes in Moussaoui Trial'. *The Washington Post*. 21 April.

³⁹ A survey of the attitudes of Muslims living in Britain found, for example, that:

- half of Muslims aged 18-24 (51%) feel that 9/11 was a conspiracy, this proportion drops to 43% amongst those aged 25-44 and 45+
- to the question "*Do you believe that Diana was killed to stop her marrying a Muslim?*" More responded 'Yes' (36%) than responded 'No' (31%).

Channel 4 (2006).

⁴⁰ $P(A | B)$.

⁴¹ $P(B | A)$.

⁴² The error committed by Fulford (2006) *supra* and others lies in not distinguishing between the probability that a jealous man is dangerous (*e.g.* might commit murder) and the radically different problem of calculating the probability that a murderer exhibits jealousy. See *infra* and Chapters 3 and 6.

⁴³ With the possible exception of those based on intuition.

context the error is best described by means of an example drawn from clinical medicine: Eddy's (1982) classic study of the misinterpretation of probability assessments in relation to mammography.⁴⁵

The problem posed by Eddy (1982) was:

The prevalence of breast cancer in a specified population is 1%. The probability that the result of mammography is positive if a woman has breast cancer is 79% and 9.6% if she does not. What is the probability that a woman with a positive result actually has breast cancer?

Eddy reports that, of 100 clinicians, 95 estimated the probability to be *c.*75%. The correct probability is *c.* 8% – a tenfold error.⁴⁶

The solution is most easily understood by translating the probabilities into a 'frequency analysis' based on a hypothetical population of 1,000.

- "the prevalence of breast cancer in a specified population is 1%" implies that 10 have cancer and 990 do not.
- "probability that the result of mammography is positive if a woman has breast cancer is 79%" implies that of the 10 that have cancer, 8 (0.79 x 10 rounded to the nearest unit) will test positive and, hence, 2 negative.
- "probability that the result of mammography is positive if a woman does not have breast cancer is 9.6%" implies that of the 990 that do not have cancer, 95 (0.96 x 990 rounded to the nearest unit) will test positive and, hence, 895 negative.

The above data can be portrayed in tabular form:

	(A): Women with cancer	(B): Women with no cancer	Total
(I): Women with positive test	8	95	103
(II): Women with negative test	2	895	897
Total	10	990	1000

Table F-1: Presence of cancer compared to mammography results.

Based on an examination of the tabular data, a positive test [Row (I)] implies that the subject has an 8 in 103 chance of actually having cancer; in contrast, if the woman actually has cancer [Column (A)], then she has an 8 out of 10 chance of testing positive. Eddy cites many medical textbooks and journals which confuse these probabilities; Sutherland cites⁴⁷ a US study which found that 95% of doctors also confuse these figures. Ayton (1995) reports that most of the staff at Harvard Medical School give incorrect answers when presented with the problem; a study by Hoffrage & Gigerenzer (1998) found that only 10% of a group of German physicians were able to determine the

⁴⁴ The 'base rate' being the rate of occurrence in the main population, of the phenomenon under examination.

⁴⁵ The use of X-rays to detect breast cancer.

⁴⁶ Ayton (1995) reports preventive mastectomies being performed on the basis of such errors.

⁴⁷ Sutherland (1992), p.173.

positive predictive value of four diagnostic tests when given the appropriate probabilistic information.

The ‘*Prosecutor’s Fallacy*’ (mentioned by the Royal Statistical Society statement on the Clark case) is also attributable to a base-rate error.⁴⁸

F-4: Base Rate errors in psychiatry

Some theoretical aspects of these errors are first discussed [F-4(i)]; the magnitude of some of the errors involved are then examined [F-4(ii)] and, lastly, the contention that the inability to apply base rate analysis can be diagnostic of psychiatric illness, is discussed. [F-4(iii)]

F-4(i): Theoretical aspects

Base rate errors are both prevalent and generally unacknowledged in academic discussions of psychiatric risk assessment (*i.e.* assessments of dangerousness, or propensity to commit acts of violence); such assessments will be discussed in Chapter 6 and (from a more theoretical perspective) in this section.

In assessing the ability of tests to predict future violence, one is faced with the problem ‘*given a positive test, what is the probability that the subject will behave violently?*’

Quite a different problem is involved when one gives the test to those who have behaved violently, and determines the proportion who have a positive test (*given that a subject behaved violently, what is the probability that he has a positive test*). Ignoring the distinction between these two problems constitutes the base rate error.⁴⁹

As an example from academic psychiatry, consider a research paper⁵⁰ entitled ‘*Forensic importance of jealousy*’ where the authors examined 200 cases of individuals who had been convicted of murder in which jealousy played a role and attempted to draw conclusions “*which will help in everyday work in forensic psychiatry in the field of*

⁴⁸ Assume that a sample of DNA found at the scene of the crime matches that of the accused; assume also that (given the accused is innocent) there is a 1-in-a-million chance of a match. The fallacy arises when a prosecutor argues that this means that there is only a 1-in-a-million chance the accused is innocent. In fact if the total population consists of 10 million then there are 10 possible matches in the whole country and thus - in the absence of other evidence - there is a 90% chance the accused is innocent. This error is essentially the same as that made by the physicians in relation to their misinterpretation of mammography results:

The physicians confused ‘*the probability of cancer (given a positive test)*’ with ‘*the probability of a positive test (given cancer)*’;

The prosecutor confuses ‘*the probability of guilt (given a positive test)*’ with ‘*the probability of a positive test (given guilt)*’.

⁴⁹ More accurately, the error is due to a confusion of two conditional probabilities $P(A | B)$ and $P(B | A)$.

⁵⁰ Muzinić (2003).

expertise and in the field of forensic psychiatric treatment".⁵¹ The authors do not advert to base rates nor to Bayesian analysis and fail to differentiate between '*the probability that an individual who is jealous will commit murder*' (the question which is of crucial significance to the clinician who wishes to assess dangerousness) and '*the probability that an individual who has committed murder, was jealous*'.

Ignoring such distinctions could have extremely serious consequences for the liberty of many individuals especially in that some eminent academic psychiatrists [*e.g.* Maden *infra*] display an almost contemptuous disdain for the subtlety of reasoning required when these issues are being discussed [*e.g.* Szmukler *infra*].

Maden, who is Professor of Forensic Psychiatry at Imperial College, London, has noted that "*Doctors have little experience of working explicitly with probability and they are not very good at it.*"⁵² McManus, who is Professor of Psychology and Medical Education at University College, London, expresses feelings similar to Maden's:

It's not easy. I'm a doctor, I teach multivariate statistics, I set questions such as this for postgraduate exams; but even though I can work it out, I still have no intuitive sense of what the correct answer is. I'm not the only one. Gigerenzer gave questions such as this to experienced clinicians who deal with these matters all the time and they had no idea either. He could see the sweat on their brows as they tried to beat these few simple numbers into shape and knew that they were failing. Eventually, most of the doctors told him that there was about a 90 per cent probability that a woman with a positive mammogram had breast cancer. That answer is very wrong. The correct answer is actually about 10 per cent.⁵³

There, however, the similarity ends. Whilst McManus (and Gigerenzer) are deeply conscious of the importance of a correct understanding of probability to medical decision making, they make serious and sustained efforts to correct the misunderstanding of fellow medical practitioners; in contrast, the response by some eminent psychiatrists to closely argued, understated criticism of psychiatric misunderstanding of probability, is to attack the messenger rather than heed the message; Maden (2001), for example, chides Szmukler for pointing out the misunderstanding of probability inherent in Dolan & Doyle's (2000) analysis. Maden (2001) begins:

I was disappointed by Szmukler's (2001) negative response to Dolan & Doyle's (2000) excellent review of attempts to measure the risk of violence in psychiatric patients. His pessimism about the practical application of structured risk assessment results from a misunderstanding of the way in which these instruments may be used. First, he emphasises the low baseline. Of course, we do not know

⁵¹ *Ibid.*

⁵² Maden (2003a).

⁵³ McManus (2002).

the baseline, as the information has never been collected accurately in this country.

And concludes:

Psychiatry must not persist in assuming that violence, an uncommon complication of mental disorder, is unimportant because of its rarity. *Reforming the Mental Health Act* (Department of Health, 2001) illustrates that concern about violence dominates the thinking of politicians in this area. It is unlikely that they are going to lose votes by overstating the level of risk associated with psychiatric patients, so the profession is going to have to come up with something better than bland reassurance.

Maden's response, in that it appears to be more mindful of the concerns of politicians than of fellow academics and, coming as it does from one who occupies a prestigious teaching post and is thus in a position to influence the education of psychiatrists, bodes ill for the practice of psychiatry as an intellectually rigorous – let alone 'scientific' – discipline.

Seeking to determine whether Maden's eschewal of rigor in relation to the use of probability is unusual, I consulted two textbooks on the philosophy of psychiatry;⁵⁴ the indices of neither made reference to any probabilistic considerations. Whilst it is understandable that such texts would not include a thorough discussion of probability (this being, rightly, the province of texts on Statistics), it might have been expected – because the use of probability assessments in psychiatric practice, is so common and the fact that their misuse can have such serious consequences – that some of the pitfalls associated with the making of such assessments, would be discussed.

Jaspers held that delusion is the "*basic characteristic of madness*"⁵⁵ and assessments of probability are intrinsic to the definition of delusion.⁵⁶ Hence it is necessary that the prevalence of beliefs – of a type which commonly feature in psychiatric diagnosis – be rigorously established. As has been shown in Chapter 3, the survey results which showed a high prevalence, within the normal population, of paranoid beliefs and of 'hearing voices', came as a complete surprise to psychiatrists practising in these areas; yet such accurate estimates are the *sine qua non* of probabilistic assessments. In their absence, common sense 'hunches' rather than science becomes the basis for diagnosis. This also appears to be the standard in relation to assessments of dangerousness:

In clinical practice, assessments of the risk of dangerousness or violence in an individual are usually based solely on clinical judgment. The unstructured clinical

⁵⁴ Radden (2004); Fulford (2006).

⁵⁵ Jaspers (1997), p.93.

⁵⁶ See, for example, Sedler (1995) *supra*.

judgment approach to risk assessment has been criticised on a number of grounds, including low interrater reliability, low validity, ...⁵⁷

In that a psychiatric diagnosis and incorrect assessment of dangerousness may lead to the loss of liberty, ‘common sense’ – irrespective of the guise under which it shelters – is surely an inappropriate standard.

F-4(ii): Magnitude of the errors involved

Dolan & Doyle’s (2000) article had as its aims “*To review the current status of violence risk prediction research*”; in analysing this article, Szmukler (2001a) commented:

... they present only one half of the story. How well do the best instruments perform in the real clinical world where prediction leads to action, including restrictions on the liberty of patients regarded as dangerous? False positives are very serious from an ethical (including resource allocation) point of view. Here we encounter the ‘base rate’ problem that the authors inexplicably fail to mention. The rate at which violent acts occur in the population of interest is critical to the predictive abilities of any instrument.

Szmukler – who is Dean of the Institute of Psychiatry at King’s College , London – is being unduly kind; as will be seen from the following tables, Dolan & Doyle’s (2000) analysis is akin to describing an iceberg simply in terms of its tip whilst completely ignoring the much larger, but hidden, problem underneath.

Szmukler examines the problem in terms of three possible base rates (*i.e.* the rates at which violence occurs in the general population): 20%, 6% and 1% concerning which he says:

Perhaps a base rate of 20% is appropriate to some forensic populations. In a community mental health service, even an inner-city one, the rate of violent acts, of any severity, over a 6-month period is more likely to be around 6%. ... , the prediction will be wrong almost nine times out of ten. For very serious violence, perhaps at a rate of 1%, the test will be wrong about 97 times out of a 100. For homicides, at around 1 in 10,000 per annum committed by patients with a psychosis, prediction is meaningless.

The following tables are constructed from the data given by Szmukler.⁵⁸

Base rate 20%	<i>(A): Violent</i>	<i>(B): Non-violent</i>	<i>Total</i>
<i>(I): Test Positive</i>	140	240	380
<i>(II): Test Negative</i>	60	560	620
<i>Total</i>	200	800	1000

Table F-2: Predicting Violence with a base rate of 20%.

Base rate 6%	<i>(A): Violent</i>	<i>(B): Non-violent</i>	<i>Total</i>
<i>(I): Test Positive</i>	42	282	324
<i>(II): Test Negative</i>	18	658	676
<i>Total</i>	60	940	1000

Table F-3: Predicting Violence with a base rate of 6%.

⁵⁷ Dolan & Doyle (2000), p.304.

⁵⁸ To facilitate comparison, the tables are in the same format as Table F-1 (*supra*).

Base rate 1%	(A): Violent	(B): Non-violent	Total
(I): Test Positive	7	297	304
(II): Test Negative	3	693	696
Total	10	990	1000

Table F-4: Predicting Violence with a base rate of 1%.

Dolan & Doyle's (2000) contention was that the tests were "better than chance" at picking out the violent from the total group of violent (*i.e.* their analysis focuses on column 'A' in each table). Szmukler's analysis examines row 'I' of each table and seeks to pick out the 'innocent' from all those who tested positive; the respective rates are 63% (240/280), 87% (282/324) and 98% (297/304); this last figure, for example, means that at a base rate of 1% [*i.e.* in the general population, 1 in every 100 is violent] whereas Dolan & Doyle believed that they were correctly identifying 7 out of every 10 violent individuals; they were actually correctly choosing 7 violent out of 304 as and wrongly identifying 297 'non-violent', as 'violent'.

Dolan & Doyle have not responded to Szmukler's criticism, and his analysis, though commented on, has not been challenged; indeed an editorial⁵⁹ in *Psychiatric Bulletin* written by Maden in response to criticisms such as Szmukler's, is dismissive and disingenuously asks "Why all the fuss?":

I have been surprised by the strength of feeling expressed by some opponents of standardised risk assessment. On the face of it, such opposition is a bizarre response to what amounts to nothing more than a special investigation. It is hard to imagine taking to the barricades in opposition to the Beck Depression Inventory, liver function tests or neuroimaging ... The best analogy is with intelligence quotient (IQ) testing. It is moderately useful to know that one's patient is a bit slow in copying a geometric design, but the true power of IQ tests lies in ranking his or her performance alongside that of his or her peers. The same is true of risk.

... The terminology of signal detection theory has been misused to argue that a 10% risk involves detaining nine false positives for every true one, resulting in the test having no value. But these instruments do not claim to identify offenders in advance, only to make statements of probability.

In that the tests have clearly high prejudicial value and little probative value the question surely is "Why use them?" unless the goal of the exercise is to hide prejudice under the mask of a spurious scientific respectability.

Whilst Maden might hold a certain scepticism towards IQ tests and tests of dangerousness, it is by no means clear that others who might have access to the results of such tests, will do so. Maden seems to show scant regard for the consequences of wrongfully labelling an individual as 'dangerous'. One wonders whether he would be equally sanguine if, say, some mandatory test was introduced for some rare but serious

⁵⁹ Maden (2003a).

infectious disease: a test which might be hailed as picking up most of those who actually had the infectious disease but which (unfortunately) labelled over 90% of those tested as being infectious, when they were not.

Maden's argument also displays a certain artfulness:

Psychiatry has a bad record of detaining patients in excessive security. All those patients who are held inappropriately in high-security were put there by doctors exercising unfettered clinical judgement. Such patients deserve a proper, standardised assessment of risk. ... Similarly, forensic psychiatry has to take seriously the statistical over-representation of patients from ethnic minorities in all locked settings and the over-representation of women in high-security. Most of these patients were locked up by White male doctors and any objective evidence of risk should therefore be welcomed.

One can only urge that Maden take his own admonition [*“Such patients deserve a proper, standardised assessment of risk”*] more seriously. Replacing a patently defective system of risk assessment with one which – unjustifiably – dons the cloak of scientific rigour, can hardly be termed an advance.

I wish to draw the following conclusion from the above discussion:

In that some eminent academic psychiatrists in discussing psychiatric risk assessment, appear to be unaware of the necessity to incorporate base rate calculations into their analysis and consequently are either unaware of, or dismissive of, the high possibility of many standard techniques of risk assessment generating false positives, their assessment of the level of dangerousness posed by any individual subject should not be assumed to be reliable.

F-4(iii): Use as a diagnostic tool

In view of the seemingly widespread inability of medical and psychiatric professionals to correctly interpret estimates of probability or to apply Bayesian analysis, it is ironic to see the inability to apply probabilistic reasoning and ‘*deviations from optimal Bayesian inference*’ being canvassed as possible diagnostic criteria for mental illness:

- Hemsley & Garety (1986) argue that their proposal “... *makes it possible to classify delusional beliefs in terms of deviations from optimal Bayesian inference*” .
- Moritz (2006) reported that their research “... *provide further evidence for the claim that schizophrenia patients make strong judgments based on little information.*”
- Davies & Coltheart (2000) summarise some recent research:

It is no part of Bentall's position that deluded subjects suffer from a gross and pervasive deficit in logical reasoning. But, he does draw attention to a body of experimental work that indicates that deluded patients perform differently, from normal subjects on probabilistic reasoning tasks. The basic finding from this research is that deluded subjects seek less information than normal controls do before reaching a judgement. In short, deluded subjects show a tendency to jump to conclusions.

... On the other hand, it may seem that this bias in probabilistic reasoning cannot be enough, by itself, to explain delusional beliefs. The performance of deluded subjects is, on average, closer to the Bayesian norms than the performance of normal subjects, who tend to be overly cautious.⁶⁰

That deluded subjects perform better than do the (statistically) normal subjects in some areas echoes a finding by Mele⁶¹ which he calls '*depressive realism*' and which is to the effect that depressed people tend to be significantly more accurate about their positive and negative attributes than do the (statistically) normal. One conclusion that might tentatively be drawn from both of these results is that (statistical) normalcy and pathology are not complementary concepts and that (statistical) normalcy should be clearly distinguished from normalcy (understood as an ideal).

⁶⁰ Davies & Coltheart (2000) p.13.

⁶¹ Mele (2004).

Appendix G: The Juklerød case

In the early 1970s, Arnold Juklerød was compulsorily detained in a Norwegian psychiatric hospital and forcibly medicated. His case became a *cause célèbre* and was the subject of intense media interest for the nearly thirty years for which it lay unresolved.

The case is exceptionally well documented: it has been discussed in the Norwegian parliament (where the central facts of the case were set forth) and in academic journals.¹

It has also been the focus of art exhibitions and films in which the psychiatrists have detailed the facts upon which they based their clinical decisions.

A factual outline is given in *Subsection G-1*. Juklerød's diagnosis and committal is examined in *Subsection G-2*. The diagnostic category '*paranoia querulans*' is discussed in *Subsection G-3*. Some observations are made in *Subsection G-4*.

G-1: The Juklerød case: The factual background

[*The following account is drawn from a statements made in the Norwegian parliament,² transcripts of contemporaneous interviews with various lawyers, academics and psychiatrists, as shown in the Sandøy films³ and a newspaper editorial.⁴*]

In 1968, as part of a wider programme of school amalgamation, the Norwegian Department of Education decided to close a school at Holtane⁵ – a school to which a local man, Arnold Juklerød, had intended to send his daughter. Juklerød was elected by the local community to head their campaign against the decision. He maintained that the school closure was in breach of the law.

Following a family dispute⁶ he was referred to Gaustad mental hospital⁷ for examination where it was his manner of conducting the school protest – rather than any family dispute – that attracted psychiatric attention. He was forcibly committed, medicated, and diagnosed as suffering from '*kverulantparanoia*'.⁸

¹ I have not been able to find any references to the case in the psychiatric literature.

² Stortinget (1995).

³ Sandøy (1997), Sandøy (2001), both films have English subtitles.

⁴ *Dag og Tid* (1996). 'Redaksjonelt: Juklerød og Stortinget', *Dag og Tid*. 30 May. [online], available: <http://www.dagogtid.no/arkiv/1996/22/leiar.html> [accessed: 11 July 2007]. Translated by Mette Roche.

⁵ A small coastal town 150 km. south of Oslo.

⁶ Of no subsequent relevance.

⁷ Now part of Oslo University Hospital.

⁸ *I.e. paranoia querulans* also known as '*Litigious Delusions*' or '*Litigious Paranoia*'. See Munro (1999), p.130.

As described in the parliamentary submission:

This *'kverulantparanoia'* consisted in Juklerød having delusions, which he would not be dissuaded from, regarding the formal breach of the law he argued ... authorities had committed by closing Holtrane school.⁹

Juklerød was released after three months but continued to dispute his diagnosis and, to that end, maintained a protest outside the hospital which resulted in his re-committal for a further 11 years, during which time he was periodically held in isolation.¹⁰

In a petition to Norwegian parliament, his predicament was identified: *"If a person protests against this diagnosis it strengthens it. But if he doesn't protest, he accepts that he is ill."*¹¹ He was discharged in 1985¹² but renewed his protest and refused to leave the hospital. On being evicted he took up 'residence' first in an alcove outside the hospital, and later in a tent where he stayed for most of the next ten years.¹³

Three months before his death¹⁴ the Department of Education wrote to him acknowledging that their school closure policy had lacked proper legal authority.

Juklerød decided to continue his protest until the psychiatrists revoked their diagnosis but they refused to comment on the government apology.¹⁵

G-2: Juklerød's diagnosis

Juklerød's diagnosis is examined from the perspective of his psychiatrists [G-2(i)]; external reviews [G-2(ii)] and some non-psychiatric academics [G-2(iii)].

G-2(i): Juklerød's diagnosis: his psychiatrists

Three of Juklerød's psychiatrists were interviewed:¹⁶ Nils Retterstøl,¹⁷ Bård Brekke¹⁸ and Ådel Grimsgaard.

Juklerød had described his diagnosis as being a stain on his character; Retterstøl addressed himself to this issue:

We hold that getting mentally ill is not shameful. It can happen to the best, when problems come up that can't be managed. That is not shameful. Nor is it a shame

⁹ Stortinget (1995). Translated by Mette Roche.

¹⁰ One such period lasted 393 days.

¹¹ Sandøy (2001).

Cf. a convict who protests his innocence and, on being offered parole on condition that he acknowledges his guilt, refuses to withdraw his protest.

¹² Stortinget (1995): "... following an 'ad-hoc meeting' of lawyers ... only two months after he, according to the medical records, was characterised as "strongly in need of treatment"."

¹³ In winter temperatures as low as -13° C.

¹⁴ In 1996, aged 71.

¹⁵ Sandøy (2001).

¹⁶ All quotations in this subsection were transcribed from Sandøy (2001).

¹⁷ Director of Gaustad Hospital.

¹⁸ Chief Psychiatrist at Gaustad Hospital.

to have gone through it. This case gives the impression that this person has been stained. A stain on his reputation. This attitude is completely strange to us.

On being asked as to the nature of Juklerød's illness, Brekke stated:

He got a very detailed answer in court. It centres on his ideas relating to the school case. He thought that a number of ministers and civil servants conspired against him. They were trying to get rid of him to avoid publicity which would lead to impeachment and a colossal scandal. This was his basic delusion.

Retterstøl was more specific:

Well his diagnosis is "*paranoid psychosis*", a mental disease with delusions of a type called "*paranoia querulans*". A querulous and delusional disorder. ... No doubt about it, he had a cause which we can agree with. But what is important is lack of adaption. Everyone experiences injustice. Everyone is at times unreasonably and unjustly treated. Then we get sad and feel down, but life goes on.

To the interviewer's comment that Juklerød: "... *seems so sound and in good health when talking but is very critical about the psychiatric establishment.*" Retterstøl replied: "*Not just that. ... His aggression is directed against the superior authorities. Psychiatry is just a part of it.*"

Asked as to why they would not revoke their diagnosis, Retterstøl commented:

No, then we would have to write a false declaration. That's like asking doctors at a cancer hospital to certify that the patient has never had cancer. That would be false.¹⁹

G-2(ii): Juklerød's diagnosis: external reviews

Juklerød had attempted to mount a legal challenge but, in the words of his lawyer:

... the judges put too much trust in the psychiatrists. When they declared Arnold had delusions the judges assumed that he had. Had the Ministry issued its admission prior to the trials the court's judgement would probably have been different. This shows that psychiatrists have too much power.²⁰

Subsequent to his being evicted from hospital, the courts had requested a further assessment:

This report concluded that at the time of committal in 1971 and 1974 "*it was not possible to confirm the basic symptoms of serious mental illness*". The Medical-Judicial Council, chaired by Gaustad's Chief Consultant Nils Retterstøl dissented from this report. A new commission was appointed. It included two of the three

¹⁹ A theme upon which Grimsgaard elaborated [Sandøy (1997)]:

As has been said several times there is no doubt about the diagnosis. It is quite typical. To use a comparison easier to understand you may compare it with a patient ill with cancer. A person with an advanced stomach cancer is being operated. He stipulates that he won't leave the hospital until he gets a declaration that he never had cancer. It's obvious that the doctors can't give him that. To us it is just as evident. We cannot give Juklerød a declaration about not having the diagnosis he has got.

²⁰ Sandøy (2001).

psychiatrists from the first commission. The new report concluded .. that Arnold Juklerød suffered from a ‘*symptom-free mental illness*’.²¹

After Juklerød’s death, a member of parliament proposed an official investigation, however:

... the Judicial Committee concluded that“... *even though the Juklerød case was special, the Committee is of the opinion that it would not be natural to suggest an extraordinary procedure such as the appointment of an investigative commission would be.*”²²

G-2(iii): Juklerød’s diagnosis: academic critiques

Per Fugelli (Professor of Social Medicine at the University of Oslo):

Medicine is like an isolation ward in our democracy. It’s practised behind closed doors. ... The doctors can also hide behind professional secrecy. There are weak traditions of democracy for the patients. Their influence is small. The medical doctor is the absolute expert. ... You may ask a medical doctor to make a diagnosis concerning a liver disease identified by a blood test. Concerning mental diagnosis, however, the boundaries towards social rebellion and political deviation become a grey zone ...²³

Georg Høyer (Professor of Social Medicine at the University of Tromsø):

A forcible commitment is a major encroachment in a person’s life. ... In Norway psychiatry confines more people than any other institution. The intentions of the psychiatrists might be good; the argument again is that they act for the patient’s benefit, that they know better than the patients what are good for them. The problem is that there is no evidence supporting this.²⁴

G-3: The psychiatric diagnosis ‘Paranoia Querulans’.

Though ‘*Paranoia Querulans*’ is not explicitly mentioned in the *DSM-IV-TR* (2000), it is listed in the *ICD-10* (2006) although its diagnostic criteria are rudimentary.²⁵

Sullivan (1956) gives a case history:

He was litigious and he had, by means of lawsuits, made it extremely awkward for number of people, including at least one very high government official. Counsel for the people against whom he had brought actions were not at all inclined to minimize the skill with which he could build up very impressive claims on the basis of what a psychiatrist could regard only as paranoid formulations, but which a jury might easily regard as an instance of an extraordinarily capable person’s

²¹ Stortinget (1995).

²² Editorial in *Dag og Tid* (1996); it continued:

And their reasoning is probably even more astonishing: “*The committee points to [the fact] that there exists a large number of people in Norway who feel they have been badly treated by official bodies and it would be unsafe if the Parliament was to establish a practice whereby some of these cases would be followed up in the form of investigating commissions.*”

²³ Sandøy (1997).

²⁴ Sandøy (2001).

²⁵ WHO (2006) p.97; F22.8 ‘*Other persistent delusional disorders*’; it states:

... The delusions are highly variable in content. Often they are persecutory, hypochondriacal, or grandiose, but they may be concerned with litigation or jealousy, or express a conviction that the individual’s body is misshapen, or that others think that he or she smells or is homosexual. ...

seeing how he was being gypped by corporations, government officials, and various people.²⁶

Munro (1999) describes the typical case:

What we are discussing here are people who have a profound and persistent sense of having been wronged and who ceaselessly and endlessly seek redress, ... Doubtless some of these individuals have suffered real grievances and have a strong sense of injustice which they are entitled to express, but it is inescapable that there are elements of psychiatric illness in at least a proportion of them ... Many patients with delusional disorder exhibit a peevish, complaintive quality but in querulous paranoia this is their most prominent feature, ...²⁷

He cites a classification made by Goldstein (1987) [*“who has had much forensic psychiatric experience”*]:

- *‘the hypercompetent defendant’* (who knows the absolute letter of the law but nothing of the spirit);
- the *‘paranoid party in a divorce proceedings’*, who is often consumed ... a sense of having been wronged ...; and
- *‘the paranoid complaining witness’* who incessantly pursues grievances.

In each case, it may take a long time to recognise that such individuals are ill, unless an experienced psychiatrist becomes involved.²⁸

It is abundantly clear from the above descriptions that the diagnosis *‘paranoia querulans’* is so ill defined as to be open to abuse.²⁹

G-4: The Juklerød Case: Some observations.

I wish to comment on the Juklerød case under the following headings: diagnosis [G-4(i)]; misdiagnosis [G-4(ii)]; stigma [G-4(iii)]; the experience of psychotropic medication [G-IV(iv)] and, lastly, the choice of default presumptions concerning coercive psychiatric intervention [G-4(v)].

G-4(i): Juklerød’s diagnosis

To establish that Juklerød was delusional³⁰ it is necessary for the psychiatrists to establish, *inter alia*, the falsity³¹ of Juklerød’s belief that the school closure policy was not sanctioned by law and that those in authority wished, for whatever reason, to conceal this fact.

²⁶ Sullivan (1956), p.306.

²⁷ Munro (1999), p.132.

²⁸ *Ibid.* p.133.

²⁹ A conclusion with which Munro (1999) agrees:

There is also a realistic concern that over-ready willingness to diagnose paranoia in an excessively litigious person might lead to abuse of psychiatry, such as occurred in Russia in the past. (p.135).

³⁰ As claimed by psychiatrist Brekke (*supra*).

³¹ *DSM-IV-TR* (2000); alternatively - if the ‘falsity criterion’ be replaced by the ‘justifiability criterion’ - to establish that Juklerød could not justify his belief. [See Chapter 3].

A disinterested observer might well ask as to what conceivable information might have been in the possession of the psychiatrists that would have been of such overwhelming force as to dispel any doubt that the schools were being closed contrary to law . Such behaviour is not unknown and – even in a democracy such as Norway – a belief that it might occur could hardly be judged, on *prima facie* grounds, to be manifestly false especially as the psychiatrists had no particular expertise in assessing the validity of legal claims. Indeed, as subsequent events demonstrated,³² the belief was true.

However it seems that the acknowledgement of the truth of the claim of one diagnosed as having ‘*paranoia querulans*’ does not dispose of the matter³³ in that the wrong at the heart of the litigious paranoid complaint need not be imaginary but may well be valid. This suggests that Juklerød’s diagnosis rested not so much on his belief but on the manner of asserting his belief;³⁴ not so much in a blind refusal to accept objective information but in a refusal to accept superior authority.³⁵

The suggestion that Juklerød suffered from a “*symptom-free psychiatric illness*” raises considerable theoretical problems. Whereas it may be meaningful to speak of a ‘symptom-free physical illness’ (*i.e.* an illness such as cancer that, as yet, presents no symptoms perceivable to the subject) such an illness does present symptoms observable to the specialist (*i.e.* physical markers exist which are detectable by objective physical tests), to speak of ‘symptom-free psychiatric illness’ is something of an oxymoron³⁶ in that a psychiatric illness is defined *only* in terms of symptoms.³⁷

The concept of ‘symptom-free psychiatric illness’ enables psychiatric diagnosis to become a self-authenticating procedure which clearly invalidates any possible claim to scientific status – how could one conceivably set about falsifying such a diagnosis?³⁸ In Juklerød’s case the term was used in the context of an external review and appears designed – much as the ‘*Emperor’s New Clothes*’ – to hide that which is clear to a disinterested observer.

³² The subsequent apology from the Department of Education (*supra*).

³³ Munro (1999) (*supra*): “*Doubtless some of these individuals have suffered real grievances and have a strong sense of injustice which they are entitled to express ...*”

³⁴ See Retterstøl (*supra*): “*His aggression is directed against the superior authorities. Psychiatry is just a part of it.*”

³⁵ See Per Fugelli (*supra*).

³⁶ Though a ‘symptom-free’ psychiatric illness might be classified as a psychiatric illness ‘in remission’; this solution however, is only apparent in that it only pushes the problem one level back: *i.e.* the problem then becomes how to distinguish between a ‘psychiatric illness in remission’; a psychiatric illness which has been cured and a psychiatric misdiagnosis.

³⁷ See *infra*.

³⁸ See the discussion in Chapter 3 on the ‘*fallacy of the missing hippopotamus*’ [Drury (1996)].

G-4(ii): Juklerød's diagnosis – was it a misdiagnosis?

Assuming, for the sake of argument, that Juklerød's original diagnosis was a misdiagnosis, then it would seem that Juklerød's conduct of his campaign to establish this fact (as manifested in its extreme tenaciousness) provided grounds³⁹ for a further and independent diagnosis of *paranoia querulans*. This is an unsettling conclusion and suggests that the important question is not as might at first sight appear, 'Was Juklerød misdiagnosed?' but rather 'How would one adjudge that Juklerød was misdiagnosed?' The unwillingness of Juklerød's psychiatrists to accept even the possibility of misdiagnosis is striking; the comparison of Juklerød's diagnosis to that of a person with an advanced stomach cancer,⁴⁰ seeks to shelter the act of making a psychiatric diagnosis under the skirts of science; in that psychiatrists (unlike oncologists) have no access to definitive biological or other scientific tests⁴¹ to validate their diagnostic findings – and *a fortiori* none to definitively diagnose *paranoia querulans* – the suggested comparison is fatuous.

Aside from the absence of definitive tests, the comparison is also misplaced because the factual circumstances which exist at the time of a psychiatric diagnosis cannot be frozen in time (unlike those which gave rise to a diagnosis of cancer where biopsy samples and X-rays may be preserved) and hence they cannot be revisited for the purposes of independent review. Except in the most unusual circumstances (as happened in the Manweiler case⁴²) contemporaneous case notes which unequivocally imply that the original diagnosis was erroneous are unlikely to exist. Thus if psychiatrists treating an individual subject come to a consensual diagnosis at any particular moment in time, a subsequent challenge to the validity of that diagnosis is, for all practical purposes, impossible. A subsequent psychiatric review of the diagnosis can, at most, determine that *at the time of the review*, the subject does not manifest any symptoms of mental illness; this is what occurred in Juklerød's case.

³⁹ See, for example, Retterstøl (*supra*):

No doubt about it, he had a cause which we can agree with. But what is important is lack of adaption. Everyone experiences injustice. Everyone is at times unreasonably and unjustly treated. Then we get sad and feel down, but life goes on.

⁴⁰ *Supra*.

⁴¹ As stated in an editorial in the *American Journal of Psychiatry* [First & Zimmerman (2006) (*supra*): Despite widespread acceptance that most psychiatric disorders are "diseases of the brain", the field of psychiatry has thus far failed to identify a single neurobiological marker that is diagnostic of a mental disorder.

⁴² See Appendix H.

The topic of psychiatric misdiagnosis is discussed in Chapter 4 where some ambiguities in the term ‘psychiatric misdiagnosis’ are identified and some distinctions introduced. In the present context, the most important of these, involves distinguishing between:

- ‘*radical misdiagnosis*’: the misdiagnosis of (psychiatric) pathology sufficient to warrant a coercive intervention, and
- ‘*technical misdiagnosis*’: the misdiagnosis of a specific psychiatric illness [*i.e.* misdiagnosing depression rather than bipolar disorder.]

The specification of the criteria appropriate to the definition of any particular psychiatric diagnostic category are matters that rightly fall to be decided by the psychiatric profession; it is they, for example, who decide that for a condition to be described as ‘schizophrenia’, certain criteria must be satisfied within a one month period rather than, say, a three month period,⁴³ but this is only part of the story: the informed public – whilst they may not be competent to adjudge on the specific diagnosis – is the rightful judge of whether the behaviour and beliefs manifested by a subject are so extreme as to warrant a coercive psychiatric intervention. I am suggesting that whilst the psychiatric profession is the rightful judge of technical misdiagnosis, the informed public – and not psychiatrists either individually or collectively – are the ultimate judges of whether an individual has been the subject of a radical psychiatric misdiagnosis.⁴⁴

Lest such a proposal appears extreme, it should be remembered that the power that psychiatrists have to initiate a compulsory detention, is not theirs as of right but is given to them by the legislature in the name of the general citizenship and it is they who should be the final arbiters as to whether the power has been exercised appropriately. It was, after all the power of an informed public that ensured that many of the diagnostic categories of past eras – homosexuality being one such⁴⁵ – that had been used by psychiatrists to define mental illness should no longer be regarded as valid; it was the power of public opinion (in the face of psychiatric assurances to the contrary)⁴⁶ that ensured the abuse of psychiatry that occurred in the Soviet Union was finally acknowledged.

⁴³ See *DSM-IV-TR* (2000), p.312.

⁴⁴ *Contra* see Sullivan (1956) *supra*.

⁴⁵ *Time* (1974).

⁴⁶ The international psychiatric community had not only been reluctant to criticize their Soviet colleagues but, prior to being pressured to change their view, had been openly admiring of the practice of psychiatry in the USSR [See Chapter 4].

In relation to the Juklerød case, this implies that in order to adjudge that Juklerød was the subject of a radical psychiatric misdiagnosis, it is not necessary to find some psychiatric consensus, nor some legal judgement; the court of an informed public opinion is sufficient and the weight of informed comment appears to be that Juklerød was indeed subjected to a misdiagnosis.

G-4(iii): Juklerød's forcible committal, was it a cause of stigma?

Retterstøl in stating that: "*This case gives the impression that this person has been stained. A stain on his reputation. This attitude is completely strange to us.*"⁴⁷ is conflating a number of issues:

- a moral issue: whether an individual should be blamed (or stigmatised) for becoming mentally ill.
- a personal issue: Retterstøl's personal belief that an individual should not be so blamed or stigmatised.
- a factual issue: whether, in point of fact, people who have been diagnosed as mentally ill are stigmatised.

Juklerød's concern was clearly with the third interpretation and it was this that fuelled his determination that his diagnosis be recognised as a misdiagnosis. The existence of such stigma is not the subject of contention⁴⁸ within academic psychiatry but is taken as a given and the focus is on how to minimise such stigma. Retterstøl was the Director of Norway's most prestigious mental hospital, he was widely published and the author of textbooks on psychiatry;⁴⁹ his (implied) denial of the existence of such stigma suggests a disingenuousness which ill serves him in relation to the credibility and reliability that should be accorded his testimony on other matters germane to the Juklerød case.

From Juklerød's perspective, the extreme intensity of the stigma to which he believed himself to have been subjected, is eloquently attested to by the persistence with which he pursued his campaign to have his diagnosis revoked.

G-4(iv): Juklerød's experience of psychotropic medication

Juklerød remembered his first injection of neuroleptic medication:

... a paralysis entered my left side, an enemy that I couldn't fight. Together with the paralysis came a fear and restlessness completely new to me. I couldn't fight it, but made efforts to behave normally. [I had] no way to struggle against this enemy. The paralysis went up my left arm. My fingers stood out like this, unmovable. It went upwards and took my mouth and pulled it up in an awkward

⁴⁷ Sandøy (1997).

⁴⁸ The literature on the stigma of psychiatric illness is extensive and is discussed in Chapter 6.

⁴⁹ Munro (1999) cites 5 references including a textbook published in the US.

position. I couldn't speak. I could hardly talk. I was terrified and frightened. Eventually I got into the office of the section head. He saw how I had changed. I cried and begged them not to give me more shots. He called the man who had given me the shots but was then told to give me a shot against the side effects.⁵⁰

The side effects of psychotropic medication are discussed in Chapter 5.

G-4(v): The Juklerød case and the choice of default presumptions

A distinction can be drawn between '*abuse of psychiatry*' and '*psychiatric abuse*',⁵¹ based on the attitude adopted by the psychiatric profession when the facts underlying such cases become known: if an instance of professional wrongdoing is speedily condemned by the psychiatric profession then it remains an isolated instance of the abuse of psychiatry, however any unwillingness to remedy such abuse transforms the case into one of '*psychiatric abuse*'.⁵²

The attitude to the Juklerød case, of those outside professional psychiatry clearly classifies it as an abuse of psychiatry; however, the obfuscation and the obstructive attitude shown by the psychiatric profession towards attempts at resolution, suggest a case of '*psychiatric abuse*'.

The prominence of the Juklerød case was achieved despite the efforts of the psychiatrists involved and was attributable primarily to the perseverance of the subject of the case, Arnold Juklerød. Without his efforts this case would have vanished into obscurity and the psychiatric misdiagnosis would have been undocumented.

Instances of '*psychiatric abuse*' – as distinct from '*abuse of psychiatry*' – undoubtedly occur in modern Western psychiatry. The extreme difficulty faced by those attempting to highlight such cases render it difficult, if not impossible, to estimate their prevalence. If a strength of character and determination (such as exhibited by Juklerød) is required before incidents of alleged psychiatric abuse can seize the attention of the public then the dearth of detailed reports of psychiatric abuse in Western countries may be more indicative of the rarity of such individuals rather than the rarity of psychiatric abuse.

⁵⁰ Sandøy (1997).

⁵¹ Professor Olofsson of the University of Växjö, Sweden makes a somewhat similar distinction between, what he terms, "*The 'bright side' of the professions*" and "*The 'dark side' of the professions.*" He considers the use of lobotomy to be an example of the dark side of psychiatry. [See Olofsson (2007)].

⁵² A similar distinction may be made in general medicine: *e.g.* the attempts by the medical profession in Ireland to prevent the facts underlying the Neary case becoming public (*supra*).

Appendix H: The Manweiler case

The Manweiler case came before the Irish courts in 2005 and concerned the wrongful psychiatric confinement and treatment of a John Manweiler. It resulted in an award of Euro 3 million damages – the highest award of general damages in Irish legal history.¹ An outline of the factual background to the case prior to committal is given in Subsection H-1, and subsequent to committal in Subsection H-2. Some observations are made in Subsection H-3.

[The following account is based on media reports; a re-enactment of the court proceedings and commentaries by psychiatrists Drs. Barry (Clinical Director, Cluain Mhuire), Kennedy (Clinical Director, Central Mental Hospital) and Walsh (former Inspector of Mental Hospitals).]

H-1: The factual background prior to committal

Manweiler entered St. Brendan’s psychiatric hospital as a voluntarily patient in September 1984. He was subsequently certified as an involuntary patient and, in December 1984, he was released as an outpatient. Whilst in hospital his psychiatrist Dr. Burke, had prescribed antipsychotic medication which, on his release, was continued for a further eleven years.

At the time of his hospitalisation Manweiler, then aged 43, and had been living with his 83-year-old mother who suffered from dementia. His relationship with his married sister, Pauline, was poor.²

In September 1984 a verbal altercation occurred between Manweiler and his mother which precipitated his later committal to a mental hospital. According to Manweiler:

I asked her if she had moved the tools and she said no, I got a bit annoyed. ... I threw the tools into a flower bed. She was very surprised and said she was afraid, that she would report me to one of the family. I couldn’t understand why she would be afraid. I never threatened her, I never threatened anyone.³

His mother complained to his sister Pauline who told Manweiler that unless he went voluntarily to a psychiatric hospital, he would be “*committed*”; he reluctantly agreed.

His diagnosis, as recorded by the admitting psychiatrist, was: “*Chronic mild depression. Schizoid personality. Short stay only. Then day care.*”⁴

¹ See O’Brien, C. (2005a). ‘€3m psychiatric detention award to be appealed’. *The Irish Times*, 6 June. The damages were subsequently reduced to Euro 500,000 in an out-of-court settlement. See O’Brien, C. (2005b). ‘€3m psychiatric award cut to €500,000’ *The Irish Times*, 24 August.

‘*General damages*’ - in contrast to ‘*special damages*’ - compensates the claimant for non-monetary harm.

² He had overheard a conversation between his mother, his sister and a solicitor on the redrawing of a will to make his sister sole beneficiary. See O’Brien, C. (2005c). ‘Vindication for a solitary man’. *The Irish Times*. 21 May.

³ *Ibid.*

⁴ *Ibid.*

The Chief Psychiatrist, Dr. Burke, who had been on leave, returned a week later and changed Manweiler's status to 'involuntary'.

H-2: The factual background subsequent to committal

The following aspects are examined:

- Manweiler's change of status [H-2(i)];
- his diagnosis [H-2(ii)];
- his medication [H-2(iii)];
- his experience of antipsychotic medication [H-2(iv)].

H-2(i): Manweiler's change of status

Manweiler's counsel [John Rogers SC], questioned Burke as to why he changed Manweiler's status to 'involuntary':

Burke:

He could have walked out giving 72 hours notice ... he was constantly grumbling about being there and was without enthusiasm.⁵

Rogers:

... There was nothing ... to show that he was anything but a very voluntary patient or that he would have left.

Burke:

There was a serious history of violence that came from the evening before when his mother left the house. ... He was expressing his unwillingness but in his own ambivalent way he wouldn't make any fuss about it ... it was for safety's sake that this had to be done.

Burke was also questioned on the procedure used to change Manweiler's status as, in the circumstances obtaining, it was not legally permissible.

Burke

It was quite usual ... that was the practice and I believe that it still is.

H-2(ii): Manweiler's diagnosis

Burke had spoken to Manweiler's family about him – but not about any family circumstances that might have precipitated the altercation – and had heard from a nurse colleague of Manweiler's sister as to the distress of Manweiler's mother on the day in question, but he had not spoken to Manweiler who had remained mute in his presence. He had diagnosed Manweiler as schizophrenic.

Rogers:

You decided this man was a schizophrenic just because he was silent?⁶

⁵ This and all subsequent exchanges between Rodgers and Burke, are transcribed from an archive recording of the Browne (2005b) except where stated otherwise.

⁶ Browne, V. (2005a). 'False imprisonment: The story of John Manweiler'. *The Village*. 5 May.

Burke:

I didn't decide then, I saw it as a possibility.

Rogers:

So what was the mental illness he had [then]?

Burke:

It was the same as he has now. He has a simple schizophrenia but it is very difficult to diagnose. ...

Rogers:

So you must have diagnosed it even though he didn't speak to you?...

Burke:

I admitted him for safety's sake and to investigate and prove he had a schizophrenic illness.

Rogers then asked Burke why, knowing of the existence of family problems, he had not discussed these with Manweiler's family.

Burke:

Well I didn't think it appropriate for me to interfere in a family matter like that. ...

Rogers:

Why not?

Burke:

Because it has nothing to do with me and could be devised [*sic*] as being difficult, it is not something that I would do lightly. ... I wouldn't dream of doing that.

Manweiler described his first meeting with Burke:

"Early on in the meeting I was requested to leave the room ... I stood outside in the main entrance hall ... it would be an hour, that length. I remember Dr. Burke came out of the room ... [and] said to me '*You are in deep trouble*'. That's the word he used '*You are in deep trouble and there's a few other items we need to discuss of a delicate nature*'. That's about all he said to me."
He said there was no further discussion then with Dr. Burke.

H-2(iii): Manweiler's medication

Manweiler (who had never been psychotic) had been prescribed the anti-psychotic *Clopixol* – a drug which may have severe side effects. Shortly before this, a psychologist's report on Manweiler – which made no mention of his being mentally ill – saw poor family communication as being the root of the problem and recommended the holding a family conference.

Burke:

... that was the psychologists view, that was not the cause of John Manweiler's illness, the illness was there anyway.

Rogers:

... it appears *Clopixol* is being prescribed in advance of the meeting the psychologist recommended?

Burke:

That was just a test dose...

In further cross-examination:⁷

Rogers:

In all the notes ... there is no note by anybody that he suffered from schizophrenia, including yourself?

Burke:

That's some oversight rather but that is my opinion, that is his illness.

Rogers:

Do you agree with me that a schizoid personality disorder is not treated with antipsychotic drugs?

Burke:

Probably not but I had to take into account his history of violence.

To counteract the side effects of the *Clopixol* Manweiler was given *Cojentin*⁸ which caused further side effects.⁹

Manweiler was discharged on a "trial" basis in December 1984 and met Burke in early January 1985. According to Manweiler:

... he said "*you are suffering from something called nerves*" and that there was no cure. Dr. Burke said he would need an injection called Clipoxil but it was too technical for him to understand the nature of that drug ... Dr. Burke said if he did not attend for the injections he could be detained in Unit 8 which is a lockup ward, and he would be forcibly administered these injections.

In his evidence Dr. Burke vigorously denied this exchange occurred.¹⁰

In 1994, a different psychiatrist stopped Manweiler's antipsychotic medication and a sympathetic nurse prompted him to make an official complaint about his earlier treatment.¹¹

H-2(iv): Manweiler: the effects of antipsychotic medication

Psychiatrists interviewed in Browne (2005a) were asked about the effect of antipsychotic medication such as *Clopixol*:

McKenna:

Clopixol is a tranquilising medication that will damp down psychotic thinking or disturbed behaviour consequent upon psychotic thinking ...
... were anybody here to ... take a dose, it would have a sedating effect.

⁷ *Ibid.*

⁸ A drug used in the treatment of Parkinson's disease.

⁹ Burke at first denied, but later accepted, the existence of such side effects.

¹⁰ Browne (2005a).

¹¹ O'Brien (2005c).

[Questioned as to side effect] you were perhaps poorly motivated couldn't, you know, do a lot. Couldn't necessarily, you know, think in a creative way. It would have an overall damping down effect.
... some of these symptoms would actually mimic chronic forms of schizophrenia ...

Walsh:

... there is probably a group of individual psychiatrists ... who would be of the view that ... the possibility of it eventually moving over into florid, frank, symptomatic schizophrenia was so great that prophylactically – as a preventive measure – such individuals might be given an antipsychotic drug ...

They were also questioned¹² on its effects on Manweiler's quality of life:

Browne:

... when he came off the drug ... suddenly his life became very much better he was able to do things he hadn't been able to do on the ten years he was on the drug. He became interested in his own condition. He read extensively on the disorder that he was said to have had, on the schizophrenia that he was wrongly – that, it appears, wrongly – he was said to have had and on the drugs that were administered to him.

Barry:

But I think it is important equally just to say that people who suffer from schizophrenia or from mental illness in general can, you know, be interested in their condition.

Browne:

My point ... is that during the years that he was on this drug he was unable to do that. In other words, this drug blighted his life for ten years and when he came off it ... the quality of his life improved significantly.

Barry:

... in relation to major tranquilisers like *Clopixol*, if somebody takes the medication that might not have reason to do so then it is more likely to be ... quite profoundly sedated ...

Manweiler described the effects of the drug therapy which was administered by way of injection every few weeks:

“One of the staff came along the ward and he had got a big medical tray with a large syringe on and he said ‘I’ve got to give you this’. Needless to say I was a bit reluctant, sort of captive in there in my pyjamas and dressing gown along with the rest of them in there, most of the time. You had not much say in the matter. About an hour after the injection was administered I got a feeling of uncontrolled movements in the shoulders and neck area.”
He was kept on this drug for over 10 years and during that time suffered the side effect of uncontrolled movements, particularly of his legs. He also told the court he frequently felt like a “zombie”.¹³

¹² Browne (2005b).

¹³ Browne (2005a).

H-3: Some observations on the Manweiler case

Observations are made under the following headings:

- the availability of legal redress [H-3(i)];
- the compliance by psychiatrists with their legal obligations [H-3(ii)];
- Manweiler's supposed 'dangerousness' [H-3(iii)]; and
- Manweiler's diminished personhood. [H-3(iv)].

H-3(i): The availability of legal redress

The *Freedom of Information Act* (1997) permitted Manweiler to seek access to his hospital file¹⁴ which contained an explicit diagnosis for which *Clopixol* was not an appropriate treatment. The unequivocal nature of the note provided *prima facie* evidence of inappropriate psychiatric treatment and, presumably,¹⁵ enabled Manweiler to surmount the obstacle placed by S. 260 of the *Mental Treatment Act* (1945).¹⁶

H-3(ii): Compliance by psychiatrists with their legal obligations

The legal obligations placed on psychiatrists by mental health legislation, are far from onerous yet scant regard was paid to them:

- the method used by Burke to certify Manweiler as 'involuntary', was unlawful, yet it appears to have been common.
- some eminent psychiatrists defended¹⁷ Burke on the ground that such technicalities interfered with psychiatrists acting in the best interests of their patients.¹⁸

A related legal matter concerns a patient's ability to refuse consent to treatment. Burke gave Manweiler's "*unwillingness*" and reluctance to consent as a reason¹⁹ for changing Manweiler's status to involuntary. Kennedy gave similar reasons:

... the other [reason why involuntary committal procedures would be invoked] is expressing your general unhappiness or unwillingness to remain in hospital. I tend to listen to my patients and if they tell me that they are unhappy, I take it that they are not consenting.²⁰

Such an interpretation eviscerates the doctrine of consent and renders it operative only in circumstances where the subject agrees with a proposed treatment; any hint of

¹⁴ Had Manweiler been treated in a private mental hospital this course of action would not have been open to him.

¹⁵ This is a surmise as I have been unable to access the court papers.

¹⁶ See Appendix A.

¹⁷ Browne (2005b).

¹⁸ There appears to be a widespread, but erroneous, belief amongst psychiatrists that to act 'in the best interests' of a patient, is an adequate defence to any ethical (or legal) challenge. [Based on my noting the views of psychiatrists whilst attending postgraduate conferences on the philosophy of psychiatry].

¹⁹ The question of dangerousness is discussed below.

²⁰ Browne (2005b).

disagreement becoming evidence of incapacity to consent.²¹ In that Kennedy is an eminent psychiatrist²² and did not appear to see himself as enunciating anything other than the general understanding of his professional colleagues, it shows a clear divergence between current psychiatric practice and the law which is set out by O'Neill (2005).²³

H-3(iii): Manweiler's supposed dangerousness

Under cross-examination, Burke stated: "*There was a serious history of violence that came from the evening before when his mother left the house.*"

As pointed out by Rogers the only evidence for this assertion was that Manweiler had been "*aggressive in voice*" towards his mother.

In that the jury not only fully accepted Manweiler's account but also penalised the defendants for their manner of defence, it can be concluded that no violence had occurred. Yet in the absence of court proceedings, Manweiler's file containing the damning phrase that he had "*a serious history of violence*" would be unchallenged and unchallengeable and would constitute the basis on which a 'risk assessment' of Manweiler's level of dangerousness would be calculated.

Barry was of the opinion²⁴ that because of the *Freedom of Information Act* (1997), psychiatrists are more reluctant to commit sensitive information to paper; this would imply that similar erroneous 'assessments' could be operative yet be beyond challenge by the patient who would not necessarily even know of their existence.

If such is the case then vague hearsay and linguistic sleights-of-hand can constitute the 'raw data' on which risk assessments are based; although such assessments might be paraded in the raiments of science, they have little in common with that discipline.²⁵

H-3(iv): Manweiler: a diminished personhood?

The contrast in the attitudes adopted by Burke towards Manweiler, and towards his family is stark: Burke barely spoke to Manweiler yet had an extended discussion with Manweiler's family whilst avoiding matters that might appear to be intrusive. Yet, on

²¹ See the comment of the physician in Amy's case (*supra*): "... the current test of rationality was often concurrence with the opinions of one's physician".

²² Dr. Kennedy is Clinical Director of the Central Mental Hospital.

²³ *Op. cit.*, p.264:

A voluntary patient cannot as a general rule be treated without his/her consent. The only exception to this rule is in emergencies where the patient due to unconsciousness is unable to communicate

...

Where a voluntary patient is deemed incapable of giving consent by reason of mental disorder steps should be taken to admit him/her to hospital as an involuntary patient ...

²⁴ Browne (2005b).

²⁵ See Chapter 6.

the basis of such partial information, Burke felt able to precipitate an intervention which would have far reaching consequences for Manweiler. Clearly Manweiler's personhood was diminished to the extent that he did not merit the consideration which Burke readily extended to Manweiler's family.²⁶

Furthermore, in discussing the events that had befallen Manweiler, the psychiatrists interviewed in Browne (2005b) were quite sanguine and – whilst one did acknowledge that the case had caused public concern – the only notes of regret expressed were in relation to the treatment of Burke in court: “*One wonders about the charitableness or the fairness of such a cross examination of a man who is retired.*”

Of greater importance to the question of personhood is the fact that Manweiler – by virtue of the forcible administration of antipsychotics – had his mental capacities reduced to those of a “*zombie*” for close to ten years. Barry implicitly acknowledges²⁷ the possibility of such effects; yet Walsh – a former Inspector of Mental Hospitals – is cavalier about the use of such drugs *as a preventive measure*.

An aside: ‘treatment’ or ‘damage’

The administration of such drugs falls under the broad rubric of ‘*treatment*’. Is this the appropriate terminology?

Harry Stack Sullivan, one of the founders of American psychiatry, described some psychiatric ‘*treatments*’ as causing a ‘*damage*’ which may reduce the occurrence of troublesome symptoms:

... [the patients] are reduced in human capabilities and drop back from a world the complexities of which provoked some insoluble conflict of adaptive impulses to one simpler and within the range of their surviving human abilities. Mental disorder is thus rectified by acquiring a mental defect, a material alteration in functional capacity for living.²⁸

Which term is more appropriate in relation to the use of neuroleptics? Barry's comments above and the existence of irreversible effects of long term use of such drugs²⁹ provides *prima facie* evidence that the question is at least worthy of further discussion.³⁰

²⁶ A possible explanation for this – and for Burke's dismissal of the psychologist's report – is that Burke saw himself as a scientist who saw Manweiler as having some ‘brain defect’ amenable only to chemical treatment, hence neither Manweiler's views nor family problems nor the psychologist's report, were of any relevance being, at best, a distraction. If this is indeed the case it presents a stark warning of the dangers lurking behind an unquestioning adherence to a scientific perspective of psychiatry. See Chapter 4.

²⁷ *Supra*: “[some of the side effects] *actually mimic chronic forms of schizophrenia.*”

²⁸ Sullivan (1964) at p.171. [Emphasis in original].

²⁹ See Chapter 5.

³⁰ *Ibid.*

In discussing the possible damage to Manweiler's personhood, the nature and intrusiveness of the harm that was done to him is of importance.

Commenting on the quantum of damages awarded to Manweiler, the legal correspondent of *The Irish Times* contrasted it with the damages awarded to a Mr. Shortt for wrongful conviction and imprisonment: "... *involuntary detention in a psychiatric hospital is a very negative experience, it is arguably less onerous than detention in prison.*"³¹ This ignores the forcible medication, the stigma and the damage to the sense of self consequent on an involuntary psychiatric committal.

The Manweiler award can be contrasted with that of a victim of rape.³² The amount of damages awarded by a jury – in that it seeks to compensate the plaintiff for his injury – provides a rough guide to the level of harm suffered by the plaintiff, as perceived by the general public. It was suggested earlier that, in some circumstances, a coercive psychiatric intervention might – in its level of its intrusiveness – be compared to a rape; the respective jury awards supports such a comparison.

³¹ Coulter, C. (2005b). 'Unsatisfactory damages neither a deterrent nor a punishment'. *The Irish Times* 13 October; she continued:

Also, Mr. Manweiler was not branded a drug-dealer, deprived of his professional standing and generally subject to public odium, as was Mr Shortt, whose family was also severely affected by what occurred.

³² *The Irish Times*, (2005a). 'Man awarded €3 million for unlawful detention'. *The Irish Times*, 29 April: ...[the Manweiler award] is the highest made by a High Court jury and comes after a €1.7 million award made earlier this month to a woman who was sexually and physically abused by her father over a number of years.

Appendix I: Iatrogenic harm and misdiagnosis in general medicine

The term ‘iatrogenic illness’ refers to illness or harm which has been (unintentionally) caused by a medical intervention. It includes cases of misdiagnosis if they occasion harm and cases where the original diagnosis was not mistaken but where subsequent interventions have an unforeseen¹ adverse effect on a subject.

As used in general medicine, the term ‘iatrogenic harm’ is usually restricted to physical harm and does not cover, for example, the psychological distress which may have resulted from a diagnosis of cancer which was incorrect, or the stigma which may befall one wrongly diagnosed as having an infectious disease such as AIDS. Thus, in so far as it is applied to the practice of psychiatry, ‘iatrogenic harm’ would generally be restricted to harm – other than foreseen but unintended ‘side effects’ – resulting from inappropriate pharmacological interventions² and would not cover any stigma or damage to personhood even if such stigma or damage flowed from an erroneous psychiatric diagnosis.

As discussed in Chapter 4, the term ‘misdiagnosis’ is – in the context of psychiatry – ambiguous; furthermore the incidence of that type of misdiagnosis which (erroneously) precipitates a coercive psychiatric intervention is, for reasons explained in the main body of the text, difficult to estimate, yet it is of considerable importance to the argument being proposed in this dissertation. The global level of misdiagnosis that occurs in general medicine provides a possible – albeit crude – estimate; hence the discussion in this appendix will focus not only on general estimates of iatrogenic harm but also on general estimates of misdiagnosis.

Contrary to what might be expected, iatrogenic harm is not restricted to those suffering from the most serious physical illnesses but extends throughout the medical health care system; estimates of this background level of iatrogenic harm are relevant to assessing the levels of iatrogenic harm that may be expected to flow from a psychiatric intervention. Furthermore, a substantial portion of the iatrogenic harm that occurs in general medicine is due to medication errors and – since pharmaceutical treatment

¹ Thus excluding foreseen but unintended ‘side effects’.

² Pharmacological interventions being the most common psychiatric treatment.

constitutes a major part of psychiatric treatment – levels of iatrogenic harm due to pharmaceutical intervention are of an especial relevance.³

The most influential studies on iatrogenic harm have been undertaken in the US and these will be discussed in *Subsection I-1*; some UK studies will be examined in *Subsection I-2* and some Irish sources, in *Subsection I-3*.

Some conclusions concerning the levels of iatrogenic harm and misdiagnosis occurring in general medicine are drawn in *Subsection I-4*; and concerning the levels of iatrogenic harm occasioned by psychiatric intervention,⁴ in *Subsection I-5*.

I-1: US estimates of iatrogenic harm and general misdiagnosis

The extent of misdiagnosis in general medicine is discussed in *I-1(i)*; that of iatrogenic harm, in *I-1(ii)*; that of iatrogenic harm occasioned by pharmacological intervention, *I-1(iii)*.

I-1(i): Misdiagnosis (US)

In 1999 the Institute of Medicine issued a report entitled *To Err is Human: Building A Safer Health System*⁵ and, although the primary focus of this report was on the level of iatrogenic harm, it did make one reference to misdiagnosis:

Unexpected findings at autopsy are an excellent way to refine clinical judgment and identify misdiagnosis. Lundberg⁶ cites a 40% discrepancy between antemortem and postmortem diagnoses.⁷

Shojania (2003) was a meta-analysis of earlier international studies and had as its objective: “*To determine the rate at which autopsies detect important, clinically missed diagnoses, and the extent to which this rate has changed over time.*”

It concluded that:

The median error rate was 23.5% ... for major errors⁸ and 9.0% ... for class I errors⁹. ... we estimated that a contemporary US institution ... could observe a major error rate from 8.4% to 24.4% and a class I error rate from 4.1% to 6.7%.¹⁰

³ The nature, and extent, of the ‘side effects’ of pharmacological psychiatric treatments are discussed in Chapter 5.

⁴ Estimates of psychiatric misdiagnosis are discussed in Chapter 4.

⁵ Institute of Medicine (1999).

⁶ *I.e.* Lundberg (1998).

⁷ Institute of Medicine (1999), p.269.

⁸ ‘Major errors’ were defined as clinically missed diagnoses involving a principal underlying disease or primary cause of death. [*Op. cit.*, p.2850.]

⁹ ‘Class I errors’ were major errors that, had they been detected during life, “would,” “could,” “possibly,” or “might” have affected patient prognosis or outcome (at a minimum, discharge from the hospital alive). [*Ibid.*, p.2850.]

¹⁰ *Ibid.*, p.2849; The authors noted (p. 2849) that the autopsy rate had decreased from 30-40% in the 1960’s to 6% in 1994; they also noted that: “*For many physicians, interest in the autopsy as a means of detecting clinically missed diagnoses is undoubtedly offset by concerns over litigation.*” (p. 2855).

Dessmon (2001) examined the incidence of misdiagnosis in an ICU (Intensive Care Unit), in all patients admitted over a two year period and concluded that:

The discordance between the clinical cause of death and postmortem diagnosis was 19.8%. In 44.4% of the discordant cases, knowledge of the correct diagnosis would have altered therapy.

I-1(ii): Iatrogenic harm (US)

Steel (1981) estimated the incidence of iatrogenic harm at a university hospital and concluded that:

... 36% of 815 consecutive patients ... had an iatrogenic illness. In 9% of all persons admitted, the incident was considered major in that it threatened life or produced considerable disability. In 2% of the 815 patients, the iatrogenic illness was believed to contribute to the death of the patient. Exposure to drugs was a particularly important factor in determining which patients had complications.¹¹

The study made a single reference to psychiatry:

If no documentation of any sort was available, no iatrogenic illness was recorded despite suspicions of the project staff that one had occurred. This problem was particularly common in cases of apparent psychiatric disturbances.¹²

This suggests:

- firstly, that the incidence of iatrogenic harm in relation to cases with a psychiatric dimension is much more opaque than in purely medical illness and,
- secondly, that the estimates of iatrogenic harm are underestimates.

Any attempt to extrapolate the study findings to psychiatric interventions is fraught with difficulties, the most obvious consideration being that the seriousness of the medical illness might be thought to have a direct bearing on the level of iatrogenic harm. On this point, the Steel (1981) study is of particular interest in that it excluded patients suffering from cancer;¹³ commenting on the study, Morris (2004) noted that:

As expected, the intensive care settings accounted for more of the iatrogenic illness than did the others. However, when subjected to a logistic analysis, the unit in which the patient received care was not a determinant of iatrogenic illness; ... it is more likely that iatrogenic illness ... are linked to limitations in human decision making and to defects in the healthcare delivery system.

If the soundness of clinical decision making and the quality of health care management are indeed the crucial factors in determining the level of iatrogenic harm then a comparison of these factors between psychiatric and non-psychiatric medical facilities, might permit a tentative estimate of iatrogenic harm due to psychiatric intervention.

¹¹ *Op. cit.*, p.76.

¹² *Ibid.*, p.77.

¹³ *Op. cit.* p.638: "... medical floor that is predominantly reserved for patients with cancer was excluded from the study because of the recognized high risk of iatrogenic complications in these patients."

The most cited¹⁴ study dealing with iatrogenic harm is known as the *Harvard Medical Practice Study* which analysed hospitalisations in New York during 1984.

It was published in two parts (the first¹⁵ concerned the incidence and the second¹⁶ the cause, of the iatrogenic harm).

I-1(ii)(a): Harvard Medical Practice Study: Incidence of iatrogenic harm

Brennan (1991) concluded that:

The Adverse events occurred in 3.7% of the hospitalizations ... and 27.6% of the adverse events were due to negligence ... Although 70.5% of the adverse events gave rise to disability lasting less than six months, 2.6% caused permanently disabling injuries and 13.6% led to death. ... There were significant differences in rates of adverse events among categories of clinical specialties but no differences in the percentage due to negligence.¹⁷

More recent reports from the US covering the years 2002-2007, found that the incidence of iatrogenic harm had not decreased over time.¹⁸

I-1(ii)(b): Harvard Medical Practice Study: Type of intervention that caused iatrogenic harm

Leape (1991) concluded that:

Drug complications were the most common type of adverse event (19%), ... The proportion of adverse events due to negligence was highest for diagnostic mishaps (75%), noninvasive therapeutic mishaps ("errors of omission") (77%), and events occurring in the emergency room (70%). Errors in management were

¹⁴ See BioInfoBank Library [online], available: <http://lib.bioinfo.pl/meid:86786> [accessed: 24 March 2007].

¹⁵ Brennan (1991).

¹⁶ Leape (1991).

¹⁷ The figure of 13.6% causing death appears unduly high when compared with the figure of 2.4% reported by Grady (2010) *infra* and suggests that it might have been a typographical error for 1.36%. In the online HTML version of Brennan (1991), the figure 13.6% is omitted ["2.6 percent caused permanently disabling injuries and percent led to death"] whilst present in the online pdf version. An examination of the full text however, shows that there was no such typographical error:

However, 2.6±0.4 percent of the adverse events gave rise to permanent total disability, and 13.6±1.7 percent caused death. Extrapolating to the state of New York in 1984, we estimated that 2550 patients suffered permanent total disability and that 13,451 died at least in part as a result of adverse events. [*ibid.* p.371]

Furthermore when the rate of fatal iatrogenic harms as a percentage of admissions, is compared the apparent disparity vanishes [Harvard (0.037 x 0.136 = 0.005 which is 0.5%); Grady (0.18 x 0.026 = 0.0047 which is 0.47%)].

¹⁸ Grady (2010):

The study, conducted from 2002 to 2007 in 10 North Carolina hospitals, found that harm to patients was common and that the number of incidents did not decrease over time. ... It is one of the most rigorous efforts to collect data about patient safety since a landmark report in 1999 found that medical mistakes caused as many as 98,000 deaths and more than one million injuries a year in the United States. ... But instead of improvements, the researchers found a high rate of problems. About 18 percent of patients were harmed by medical care, some more than once, and 63.1 percent of the injuries were judged to be preventable. Most of the problems were temporary and treatable, but some were serious, and a few — 2.4 percent — caused or contributed to a patient's death, the study found.

Grady, D. (2010). 'Study Finds No Progress in Safety at Hospitals'. *New York Times*. 24 Nov.

identified for 58% of the adverse events, among which nearly half were attributed to negligence.

Of the interventions that caused iatrogenic harm, two – ‘*diagnostic mishaps*’ and ‘*drug therapy*’ – would appear to be of most relevance to psychiatry. Estimates of iatrogenic harm due to inappropriate use of drugs – whether incorrectly prescribed, dispensed or administered – are given later in this appendix.

The studies cited above, relate to the mid 1980’s, the Institute of Medicine’s report (*supra*) relates to the late 1990s and, whilst it did not explicitly advert to iatrogenic harm caused by psychiatric intervention, it did estimate the general level of iatrogenic harm based on two studies¹⁹:

In both of these studies, over half of these adverse events resulted from medical errors and could have been prevented. When extrapolated ... the results of the [first] study ... imply that at least 44,000 Americans die each year as a result of medical errors. The results of the [second] suggest the number may be as high as 98,000.

Even when using the lower estimate, deaths due to medical errors exceed the number attributable to the 8th leading cause of death. More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).²⁰

The above estimates were garnered by the medical profession; patient groups provide an alternative – and possibly more authoritative²¹ – perspective: a survey²² conducted by the National Patient Safety Foundation – a group affiliated to the American Medical Association – on the public experience of patient safety issues, found that 33% of the respondents had personally experienced a medical²³ mistake, the most common being ‘*misdiagnosis/wrong treatment*’ (40%) followed by ‘*medication error*’ (28%). One in three respondents (32%) reported that the medical mistake had a permanent negative effect on their health.

¹⁹ Institute of Medicine (1999), p.1:

Two large studies, one conducted in Colorado and Utah and the other in New York, found that adverse events occurred in 2.9 and 3.7% of hospitalizations, respectively. In Colorado and Utah hospitals, 6.6% of adverse events led to death, as compared with 13.6% in New York hospitals.

²⁰ *Ibid.*

²¹ See Basch (2010):

The current drug-labeling practice for adverse events is based on the implicit assumption that an accurate portrait of patients’ subjective experiences can be provided by clinicians’ documentation alone. Yet a substantial body of evidence contradicts this assumption, showing that clinicians systematically downgrade the severity of patients’ symptoms, that patients’ self-reports frequently capture side effects that clinicians miss, and that clinicians’ failure to note these symptoms results in the occurrence of preventable adverse events. (p.865)

... Patients’ reports are more highly concordant with overall health status than clinicians’ reports. (p.867)

²² NPSF (1997).

²³ The survey made no reference to psychiatry or to mental illness.

I-1(iii): Iatrogenic harm due to pharmacological intervention (US)

Lazarou (1998) was a meta-analysis of earlier studies on the incidence of adverse drug reactions (ADRs) in hospitalised patients; it found the level of ADRs to be “*extremely high*” and concluded that:

... the overall incidence of serious²⁴ ADRs was 6.7% and of fatal ADRs was 0.32% ... [it] estimated that in 1994 overall 2,216,000 ... hospitalized patients had serious ADRs and 106,000 ... had fatal ADRs, making these reactions between the fourth and sixth leading cause of death.

These are underestimates because the study “... *excluded errors in drug administration, noncompliance, overdose, drug abuse, therapeutic failures, and possible ADRs*”.

In 2006, following its earlier report on medical errors, the Institute of Medicine released a study on medication errors in American hospitals; amongst its findings²⁵ were that:

- At least 1.5 million Americans are sickened, injured or killed each year by errors in prescribing, dispensing and taking medications ... drug errors cause at least 400,000 preventable injuries and deaths in hospitals each year, more than 800,000 in nursing homes ... and 530,000 ... in outpatient clinics.
- Mistakes in giving drugs are so prevalent in hospitals that, on average, a patient will be subjected to a medication error each day he or she occupies a hospital bed, ...

The report urged the adoption of computerised systems for prescribing drugs, a proposal – which despite having been routinely made since 1999 – has been followed in less than 10% of hospitals.²⁶

I-2: The United Kingdom

The extent of misdiagnosis in general medical practice is discussed in *I-2(i)* and the extent of iatrogenic harm, in *I-2(ii)*.

I-2(i): Misdiagnosis (UK)

Although I have been able to source statistics on the rate of misdiagnosis for various medical conditions, for example:

- epilepsy: estimates vary between 20-31%.²⁷
- PVS: estimates vary between 18-43%.²⁸

I have been unable to locate global estimates of medical misdiagnosis.

²⁴ *I.e.* those that required hospitalization, were permanently disabling or resulted in death.

²⁵ Kaufman, M., (2006). ‘Medication Errors Harming Millions, Report Says’. *The Washington Post*, 21 July.

²⁶ McNeil Jr., D. (2007), ‘Medication Errors Are Studied’, *The New York Times*, March 7.

²⁷ NICE (2004b).

²⁸ Andrews (1996) found a misdiagnosis rate of 43%; Tresch (1991) found that 18% of patients who were diagnosed as PVS, were aware; for a further discussion of these, and other, sources see Roche (2000).

In the UK, The National Patient Safety Agency (NPSA) is charged with monitoring and overseeing patient safety, a search of its online reports for ‘misdiagnosis’ elicits 4 results, none of which is relevant. The NPSA, however, does provide estimates of iatrogenic harm.

I-2(ii): Iatrogenic harm (UK)

NPSA (2001) contained the following table:

	<i>Harvard (1991)</i>	<i>Australian (1995)</i>	<i>UK pilot</i>
<i>Percentage of inpatient episodes leading to harmful adverse events</i>	3.7%	16.5% (8.25% preventable)	10%
<i>Implication for English NHS hospitals (based on 8.5 million inpatient episodes)</i>	314,000 Adverse Events	1,414,000 Adverse Events	850,000 Adverse Events

Table I-1: Frequencies of adverse events in UK hospitals

NPSA (2001) also highlighted the statistic that for every major injury or death there are 10-50 minor injuries and 300-600 related near misses – a statistic which is of interest in that deaths due to pharmacological causes are recorded in Irish psychiatric hospitals and it may permit a tentative estimate of non-fatal adverse reactions; the statistic that 10% of hospital admissions lead to patient harm is also of interest.

A 2005 report by the National Audit Office found that 10.8% of patients experienced an adverse event; it found that 2,081 deaths were attributed to the errors of staff, but said:

It is widely acknowledged there is significant under-reporting of deaths and serious incidents. Other estimates of deaths range from 840 to 34,000. In reality, the NHS simply does not know.²⁹

The finding that, in a third of NHS hospitals, there is no requirement on clinicians to report unexpected complications or unexpected events, further emphasises the extent of underreporting.³⁰

A 2006 report from the NPSA noted that :

International research suggests that there is significant under-reporting of incidents. ... [and] biases in what types of incident are reported. ... [though] reports from mental health ... services have increased rapidly.³¹

This report also noted that no reports from patients have been included in their analysis but that a system was being implemented to permit such reports.³² This issue is of special importance in psychiatry because – as is the case in relation to the concept ‘illness’ – the defining, the measuring and the assessing of ‘harm’ is much more

²⁹ Carvel, J., (2005). ‘More than 1m patients fall victim to mistakes in NHS hospitals’, *The Guardian*, 3 Nov.

³⁰ NPSA (2001).

³¹ NPSA (2006a).

³² *Ibid.*, p.3.

problematic³³ than in general medicine. The ability of patients, ex-patients or ‘survivors’³⁴ to influence the perception of harm should – in the light of past practices such as lobotomy – be readily apparent.

In a further report³⁵ the NPSA specifically addressed the issue of patient safety in mental hospitals. It does not refer to misdiagnosis but is informative in relation to adverse reactions to psychotropic medications.

I-3: Ireland

I have been unable to source specifically Irish statistics on general rates of misdiagnosis.

Some indicators as to the extent of iatrogenic harm occurring in Irish medical practice, are discussed in *I-3(i)*; and of iatrogenic harm occasioned by pharmacological intervention, in *I-3(ii)*.

I-3(i): Iatrogenic harm (Irl.)

In 2003, seeking to investigate the extent of iatrogenic harm occurring in Ireland, an RTE *Prime Time* programme,³⁶ found that research in this area was non-existent; it incorporated interviews with, amongst others, Professor Fitzgerald (Dean of Medicine, UCD) and Professor Leape (author of one³⁷ of the Harvard studies *supra*).

Fitzgerald accepted that the result of the Harvard study applied to Ireland and that the problem was of a seriousness sufficient to warrant an independent investigation because the number of deaths due to iatrogenic harm exceeded, for example, those due to road accidents.

Leape, in discussing the estimate that should apply to Ireland, noted that the Harvard finding that iatrogenic harm occurred in 4% of hospitalisations related to the US and that estimates from other countries were considerably higher: 13% (Australia), 10% (UK) and 9% (Denmark). He suggested 10% as an initial estimate for Ireland however

³³ See Chapter 4.

³⁴ The term ‘survivor’ is the preferred usage of those former patients who are critical of their experience at the hands of psychiatry. See, for example, Rissmiller & Rissmiller (2006) and a response by Emerick (2006):

... more than 60% of ex-patient groups support antipsychiatry beliefs and consider themselves to be "psychiatric survivors." Many in the "mad liberation" movement believe they are victims of psychiatric treatments that harmed them. ... Given the extensive critical literature on the concept of "mental illness" and the size of the ex-patient movement, the objective observer might conclude that psychiatry is less scientific and more political than the Rismillers (*sic*) suggest and that the ex-patient movement is more scientific, more antipsychiatry, and a more important social movement than most people understand it to be.

³⁵ NPSA (2006b).

³⁶ RTE (2003).

³⁷ Leape (1991).

the informality of the discussion was such that the only conclusion that can reasonably be drawn is that the rate of iatrogenic harm in Ireland is at least comparable to that found in the United States.

The Deputy Chief Medical Officer for England was also interviewed; he emphasised the importance of first determining the extent of the problem because, in the absence of such information, the prevalence of iatrogenic harm is likely to be denied³⁸ – a response eloquently demonstrated by the response of the spokesman for the Irish Hospital Consultants Association who was also interviewed.

A spokesperson for Patient Focus (a patients' rights group) emphasised the importance of access to the courts in uncovering the extent of iatrogenic harm; in that, in Ireland, such access is effectively denied³⁹ to those who seek redress for harm caused by negligence psychiatric practice, it follows that an important avenue for estimating the prevalence of psychiatric iatrogenic harm, is not available.

I-3(ii): Iatrogenic harm due to pharmacological intervention (Irl.)

Interviewed on RTE (2003), the chief pharmacist of Tallaght Hospital described the effect of installing a system to monitor the extent of pharmacological errors occurring in the hospital. Prior to the introduction of this system⁴⁰ the extent of reporting amounted to 12 drug errors⁴¹ per year; subsequent to the introduction, it rose to 500 per year.

Indicators to the extent of underreporting of ADRs can also be gleaned from the submissions⁴² made to, and the report⁴³ of an Oireachtas Sub-Committee especially constituted to examine the adverse effects of pharmaceutical products.

I-3(ii)(a): Submissions relating to the reporting of ADRs

The chairman of the Pharmaceutical Society of Ireland, stated:

The incidence of reporting of adverse events by all practitioners — medical, pharmaceutical, dental and nursing in the Republic — is low by European and international standards.

³⁸ A spokesperson for a US patient group, also interviewed in the programme, stated “*What gives us power is that we already have the data – if you don’t have the information they will say what information? What evidence?*”

³⁹ See *Mental Health Act* (2001), S. 73.

⁴⁰ The system sought to encourage rather than punish those who reported errors and which, in an Irish context, was novel.

⁴¹ This relates to errors missed by ward pharmacists who detect c.1,000 errors per month.

⁴² *Oireachtas Sub-Committee on the Adverse Side Effects of Pharmaceuticals* (2006).

⁴³ *Oireachtas Joint Committee on Health and Children* (2007).

... Pharmacists ... do not currently have a legal obligation to report adverse effects.⁴⁴

This picture was confirmed by the Medical Director of the Irish Pharmaceutical Healthcare Association, who stated that the annual number of reported ADRs was “... approximately 2,500 ... of which more than 60% are reported by pharmaceutical companies.” This implies that only 1,000 ADRs were reported by medical practitioners directly to the IMB.⁴⁵ In acknowledging the low level of reporting, he related his own experience:

... I did some research on this issue 14 or 15 years ago when I was working in St. James’s Hospital. The junior hospital doctors ... were given a small financial incentive to report adverse events when they occurred. Within a three-month period doctors ... reported more adverse events than had been reported in the previous eight years.

As mentioned above, the Harvard estimates as applied to Ireland suggest that iatrogenic harm accounted for 4,000 deaths; of which 19% (*i.e.* 760) were attributable to pharmaceuticals. In relation to ADRs, the ratio of serious adverse events to fatal adverse events was in the ratio 21:1⁴⁶ which suggests that the total number of ‘serious ADRs’⁴⁷ occurring annually in Ireland is 15,906.⁴⁸ Whilst many of these ADRs are attributable to inappropriate prescription or administration of drugs, it is clear that a proportion are attributable to the side effects of medication. Given that knowledge of the nature and extent of ADRs is an obvious prerequisite to remedial action, it is difficult to comprehend why the Committee did not pursue the reasons for the low reportage of ADRs more forcefully.

I-3(ii)(b): The Report: Extent and Seriousness of ADRs

The Committee found that underreporting of ADRs was common and noted that whilst no comprehensive studies existed of the prevalence of ADRs in Ireland, some studies relating to individual hospitals, had been made:

[one such] study ... identified prescribing errors of 31.1% for in patients in a Dublin teaching hospital and another ... reported an error rate of 25% in the out patients department.

⁴⁴ *Oireachtas Sub-Committee on the Adverse Side Effects of Pharmaceuticals* (2006), submissions of 10 Oct.

⁴⁵ The Irish Medicines Board (IMB) is the competent authority. Lexchin & O’Donovan (2010) report a possible conflict of interest between the IMB and the pharmaceutical industry.

⁴⁶ Lazarou (1998) (*supra*) “...the overall incidence of serious ADRs was 6.7% and of fatal ADRs was 0.32%” [GR: 6.7/0.32=20.93]

⁴⁷ ‘Serious ADRs’ were defined as those that required hospitalization, were permanently disabling, or resulted in death.

⁴⁸ This figure relates to those ADRs deemed ‘serious’; the total number of ADRs is clearly of a higher order of magnitude.

... two medical insurers calculated that 25% and 19% respectively of claims against GPs in Ireland were for medication errors.
 ... [a study of] 600 geriatric patients ... at the Cork University Hospital found that 52% were given inappropriate medicines.⁴⁹

I-3(ii)(c): The Report: The Role of Pharmaceutical Companies

The FDA ... points out that most drugs are approved on the basis of trials on subjects totaling not more than 1,500. ... the form of drug trials is such that ADRs are likely to be overlooked. Indeed, companies can structure tests with that objective in mind. Furthermore ... drug companies are not obliged, or do not, make available all studies to regulators.⁵⁰

Some of the Report’s strongest criticisms relate to psychiatric medication and these are discussed in Chapter 5.

I-4: Conclusions relating to the levels of iatrogenic harm and misdiagnosis in the practice of general medicine in Ireland.

The conclusions relating to general medical practice, concerning levels of misdiagnosis are given in *Subsection I-4(i)*; those relating to iatrogenic harm, in *Subsection I-4(ii)*; and those relating to ADRs, in *Subsection I-4(iii)*.

I-4(i): Misdiagnosis

Leape (*supra*) suggested 10% as an initial estimate of the rate of iatrogenic harm in Ireland; a figure considerably in excess of the US rate at 4% however as stated earlier this was an estimate given informally and without accompanying evidence. The only conclusion that was drawn was that the rate of iatrogenic harm in Ireland is at least comparable to that found in the United States; similarly it would seem reasonable to conclude that, in the absence of authoritative studies, the rate of misdiagnosis in Ireland is at least as high that those found in the US which are summarised in *Table I-2 (infra)*.

<u>Study</u>	<u>Rate</u>	<u>Type</u>
<i>Lundberg (1998)</i>	40%	Postmortem
<i>Shojania, K. et al (2003)</i>	Major error rate: 8.4% – 24.4% Class I: 4.1% – 6.7%	Meta-analysis of autopsy studies on misdiagnosis
<i>Dessmon, Y. et al (2001)</i>	19.8%	Direct study of the rate of misdiagnosis in an ICU

Table I-2: Estimates of misdiagnosis in general medicine

Based on such considerations, it may be concluded⁵¹ that a conservative estimate of the rate of misdiagnosis in general (*i.e.* non-psychiatric) medical practice in Ireland, is in the region of 25%.

⁴⁹ *Op. cit.*, Para 3.5.

⁵⁰ *Ibid.*, Para 4.4. See also Chapter 5.

⁵¹ The ‘Precautionary Principle’ (*supra*) adds independent support to this conclusion.

I-4(ii): Iatrogenic harm

US and UK estimates of the rates of iatrogenic harm and ‘*major*’ or ‘*fatal*’ harm are shown in the following table:

<i>Study</i>	<i>Rate</i>	<i>Major or Fatal</i>	<i>Comments</i>
<i>Steel (1981)</i>	36%	- of which 25% major 5% fatal	Exposure to drugs was a particularly important factor
<i>Harvard (1991)</i>	3.7%	- of which 13.6% fatal	Drug complications were the most common type of adverse event (19%)
<i>Institute of Medicine (1991)</i>	2.9% to 3.7%	- of which 6.6% to 13.6% fatal	
<i>Australian (1995)</i>	16.5%		
<i>UK (2005)</i>	10%		Significant under-reporting of deaths and serious incidents.

Table I-3: Estimates of iatrogenic harm in general medicine

The studies summarised in *Table I-3*, suggest 10% as a tentative estimate of the proportion of iatrogenic harms that result in fatalities; inappropriate pharmaceutical treatments being a common source of such harms.⁵²

I-4(iii): Medication errors and level of reporting of ADRs in Ireland

The report of the Oireachtas sub-committee cited estimates of the levels of medication errors occurring in individual Irish hospitals ranging from 25% to 52%; in the absence of evidence to the contrary,⁵³ these can be taken as generally representative.

Furthermore, based both on the evidence given to the sub-committee and on its own conclusions, ADRs are grossly underreported in Ireland.⁵⁴

*I-5: Iatrogenic harm in Irish psychiatric practice*⁵⁵

Had the iatrogenic consequences of psychiatric interventions (including medication) received the same level of scrutiny as has non-psychiatric interventions, then the *excursus* into discussing the general levels of iatrogenic harm (such as has been undertaken in earlier sections of this chapter) would not have been necessary; but such studies do not exist and it is only by means of such a circuitous route that estimates of harm caused by psychiatric intervention can be made.

It is clear that the uncovering of iatrogenic harm due to drug errors can only occur in an environment where there is an obligation to maintain accurate and detailed records. As

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ In a letter to *The Irish Times* [22 October 2009] Dr. Orla O’Donovan of the Department of Applied Social Studies, University College Cork, stated: “In 2007, the IMB received only 206 ADR reports from GPs, indicating that fewer than one in 10 GPs on average submit one ADR report a year to this voluntary reporting system.”

⁵⁵ The following discussion is restricted to pharmaceutical treatments [see *supra*].

evidenced by the reports of the Inspector of Mental Hospitals, Irish psychiatric practice is deeply remiss in this regard:

... drug prescribing in some locations is often arbitrary and made without regard to appropriate clinical diagnosis. ... In some instances, the prescriptions had not been reviewed for some considerable time. ... There appeared to be an increasing number of sudden deaths in psychiatric hospitals, some of which were attributed to drug-related effects.⁵⁶

This raises the question as to the default presumptions that should be decreed in cases where full information on the level of harm consequent on psychiatric intervention, is unavailable: should examples of such harm be regarded as isolated [the “*few bad apples*” scenario] or as indicative of a considerably more extensive problem [the “*tip of the iceberg*” scenario]. The problem is discussed *infra*.

Two case histories are discussed [*Subsection I-5(i)*]; the first [the Cromer Case] provides a window into institutional attitudes towards the reporting of adverse patient events in a psychiatric institution; the second [the Neary Case] is indicative of the unwillingness of the medical professional bodies, at the highest levels, to actively uncover and resolve cases of serious and sustained iatrogenic harm.

Some of the Oireachtas Sub-Committee’s conclusions concerning psychiatric medications are discussed in *Subsection I-5(ii)*; and some conclusions are drawn in *Subsection I-5(iii)* concerning the extent of iatrogenic harm occurring in Irish psychiatric practice.

I-5(i): The Cromer and Neary cases

The Cromer case concerns an inquiry into the death of an elderly psychiatric patient, a Ms. Hannah Cromer, who, having been originally diagnosed as schizophrenic, had been hospitalised for 35 years. Ms. Cromer choked to death whilst restrained to a chair by a belt,⁵⁷ but was reported by hospital staff as having “*passed away*” and the information relating to the exact circumstances of the death was not recorded in case notes. Staff removed Ms Cromer’s body and “*dressed her in new clothes ‘for her dignity’*.”⁵⁸

⁵⁶ Walsh (1998), pp.3–4; and also:

The Inspectorate is concerned about the adequacy and quality of medical note taking in some mental health services. This relates particularly to consultant inputs both on, or shortly after, admission to hospital and subsequent clinical reviews and progress.

⁵⁷ O’Riordan, S. (2007) “Gardaí ‘made me change my statement on patient’s death’ ” *The Irish Examiner*, 5 April.

Roche, B. (2007), ‘Hospitals urged to examine rules on restraint’, *The Irish Times*, 5 April.

⁵⁸ O’Riordan (2007) (*supra*).

Ms. Cromer's GP regarded the death as unexpected and reported it to the Garda Síochána. A post mortem "... was emphatic that Ms. Comber died from asphyxia as a result of her neck becoming entangled in the restraining belt of her chair."⁵⁹

In their initial statements to the guards, the two nursing staff who had been present, stated that Ms. Comber had slipped down in her chair and the belt became entangled around her neck and she became asphyxiated. These statements were withdrawn at the inquest with one nurse claiming that she had been coerced by the guards into making her statement. A verdict of misadventure was returned.

The Comber case is not an isolated example of the concealment of iatrogenic harm in Ireland:⁶⁰ the investigations⁶¹ consequent on the disciplinary hearings relating to the obstetrician Dr. Neary⁶² provide ample evidence to the existence in Ireland of a culture⁶³ amongst medical professionals – not only of unwillingness to highlight medical errors – but to actively conceal⁶⁴ such errors. (It should be noted that the Lourdes Inquiry found no evidence of bad faith on the part of Dr. Neary and – had the events in question occurred in a psychiatric setting – the absence of *male fides* would be a substantial bar⁶⁵ to a patient taking a civil action against Dr. Neary.)

⁵⁹ Roche (2007) (*supra*).

⁶⁰ See also Chapter 6 concerning a report [MHC (2009)] into allegations of ill-treatment of patients in two mental hospitals in County Tipperary. The inquiry had been prompted by reports of high levels of fractures being suffered by patients and this had led to suspicions of staff abuse of patients and calls for a Garda inquiry. The reports first came to light in 2004 and were not discussed by the regional authorities until 2005 and then not fully investigated.

⁶¹ Harding-Clarke (2006).

See also the reports of the Medical Council of Ireland investigation into the behaviour of Dr. John Murphy, Dr. Bernard Stuart and Professor Walter Prendiville who had, in an earlier inquiry, exonerated Dr. Neary. [Online], available:

<https://www.medicalcouncil.ie/news/publicationsarticle.asp?NID=182&T=N> [accessed: 9 April 2007].

⁶² Harding-Clarke (2006). Dr. Neary had performed a number of caesarean hysterectomies on patients which were not justified on medical grounds and some of which had been performed against the patients' express wishes.

⁶³ In that subsequent to events leading to the establishment of the Lourdes Inquiry becoming public, Dr. John Murphy – one of the three consultants who had exonerated Dr. Neary – was elected as President of The Royal College of Physicians in Ireland though he subsequently resigned this position.

See Wall, M. (2007) 'RCPI president resigns after Neary inquiry', *The Irish Times*, 22 February.

⁶⁴ A report commissioned by the Medical Council of Ireland found that some complaints made to the Council against Neary, were not acknowledged or not recorded and investigations were subject to long delays.

See Bowers, F. 'Lessons from Neary controversy' *Irish Health.com* [online], available:

<http://www.irishhealth.com/index.html?level=4&id=5111> [accessed: 9 April 2007].

One of the consultants who had exonerated Neary, did so with the words: "... it is my view that the mothers of the North Eastern Health Board are fortunate in having the service of such an experienced and caring obstetrician." [See Harding-Clarke (2006) p.13].

⁶⁵ See Appendix A.

I-5(ii): Oireachtas Sub-Committee⁶⁶ on psychiatric medications⁶⁷

- Submissions::

Executive Summary:

4. ... It was asserted that these medicines had dangerous, even fatal side effects, yet were prescribed extensively.

4.1. ... submissions made a number of points:

- ... the drugs are often prescribed on the basis of very limited observation of the patient;
- they generate side effects which are misdiagnosed as causal, leading to further medication;
- the side effects include, behavioural disorders, physical illness, dependence, suicidal ideation and even suicide;
- ... even where the risks of these side effects are well known they seem not to be fully appreciated or are ignored by prescribers;
- ... even setting aside the risk of side effects, some of the drugs are of doubtful benefit.

4.12. ADRs may arise because practitioners have an exaggerated view of the benefit of the drugs in relation to its drawbacks.

- Conclusions::

5.3. ... the influence of the pharmaceuticals industry ... is unhealthy and needs to be counterbalanced.

5.5. ... need to assign a higher priority to pharmacovigilance activities, including reporting of ADRs.

5.23. ... the excessive use of medication prescribed by health care professionals and excessive use of psychiatric drug therapies in particular. Some of the responsibility for this lies in the promotional activities of the drug companies ...

I-5(iii): Conclusions relating to the levels of iatrogenic harm in Irish psychiatric practice

The extent of iatrogenic harm in Ireland is being uncovered by a haphazard process – the circumstances surrounding the death of Ms. Cromer were uncovered despite the efforts of the psychiatric medical professionals, a series of fortuitous circumstances lead to the uncovering of Dr. Neary's malpractice – other countries have adopted a much more proactive stance.⁶⁸

In the absence of such institutions in Ireland – and, therefore, in the absence of reliable, detailed statistics in relation to iatrogenic harm – how should the risk of such harm be

⁶⁶ Oireachtas Joint Committee on Health and Children, (2007).

⁶⁷ The Oireachtas subcommittee report did not consider errors in diagnosis. [*Op. cit.*, Para. 4.10.]

⁶⁸ For example:

- in the UK, the establishment of the NPSA (*supra*),
- in Sweden, the 'Lex Maria' – which was enacted as early as 1937 – sought to ensure mandatory reporting of any serious patient injury, or even risk of serious injury, and extends to the psychiatric services. [See Ödegård (1998)].

incorporated into discussion of medical decision making? When it is known that iatrogenic harm does indeed occur, can any conclusions be drawn in relation to the prevalence of such harm? What should the ‘default’ presumption be?

At the extremes, two conclusions are possible:

- (i) that, cases such as the Neary, Cromer and other cases, are isolated cases; *i.e.* adverse events occur to an extent commensurate with their reporting [the “*few bad apples*” scenario].
- (ii) that such cases are indicative of a pervasive laxity towards the reporting of adverse events in Irish hospitals and, in particular, Irish psychiatric hospitals; *i.e.* adverse events occur to an appreciably greater extent than is reported [the “*tip of the iceberg*” scenario].

The principles underlying the choice of default assumptions have been examined in Chapter 1 and the conclusion drawn that the Precautionary Principle is applicable and favours the adoption of the second option. Furthermore, the adoption of the first of the above options, would tend towards an acceptance of the *status quo* and its lax practices in relation to patient safety, whereas adopting the second create a momentum towards uncovering adverse events and consequently minimising harm; I suggest that the conclusion must be drawn that, in the absence of robust evidence to the contrary, the default presumption should be that adverse events occur in Irish Hospitals and, in particular, Irish psychiatric hospitals, to an extent appreciably greater than is reported.

As an indicator of the extent of underreporting, I will attempt (by using statistics discussed in earlier section of this chapter) to estimate the number of deaths that might be expected to occur in one year in Irish Psychiatric Hospitals because of iatrogenic effects of pharmaceutical treatments, and then compare it with the estimate made by the Inspector of Mental Hospitals.

[For the purposes of analysis I have taken the year 1998 as a base principally because statistics for the number of sudden deaths attributable to psychotropic medication have been made available by the Inspector of Mental Hospitals for that year.]

- (i) The total number of admissions to Irish psychiatric hospitals in 1998 was 21,895.⁶⁹
- (ii) The Harvard Study (*supra*) estimated the number of adverse events for the US (as a percentage of total hospitalisations) as 3.7%;⁷⁰ Leape, one of the authors of the

⁶⁹ Walsh (1998), Table 4.

⁷⁰ Brennan (1991) (*supra*): “Adverse events occurred in 3.7% of the hospitalizations ...”

report, suggested 10% as an appropriate estimate for Ireland⁷¹ however, as stated above, this was an estimate given in informal circumstances and the conclusion that was drawn (*supra*) was that the rate for Ireland was at least comparable to the United States.

(iii) Assuming the level of iatrogenic harm in psychiatric hospitals equates⁷² with that of non-psychiatric hospitals, this suggests that 810 patients suffered iatrogenic harm in Irish psychiatric hospitals in 1998.

(iv) Removing all non-pharmacologically related iatrogenic harm⁷³ from consideration so that the focus is placed solely on ‘*drug complications*’, permits the number of psychiatric admissions likely to suffer iatrogenic harm due to medication, to be estimated; this figure is 154.⁷⁴

(v) Of these 154,⁷⁵ 15 would be expected to suffer fatal complications.

(vi) The Inspector of Mental Hospitals has only identified seven deaths in 1998 relating to the ‘*side-effect of psychotropic drug administration*’;⁷⁶ in that the Inspector makes no reference to deaths due to incorrect administration or prescription of medications, it appears that this figure should be interpreted as being the total number of iatrogenic fatalities due medication.

I wish to draw the conclusion that the level of fatal iatrogenic harm caused to psychiatric inpatients by psychiatric medications exceeds, by orders of magnitude, that reported by the Inspector Of Mental Hospitals.

⁷¹ *Supra*

⁷² Because certain procedures - such as surgery – which may be thought to incur a higher risk of iatrogenic harm (though see the earlier discussion for an alternative point of view) are far more common in non-psychiatric hospitals than in psychiatric hospitals, this presumption may be questioned; though it should be noted that the estimate in the following paragraph omits 81% of such harm from consideration which may be thought to err in the opposite direction.

⁷³ Which constitutes 81% of iatrogenic harm; see Leape (1991) (*supra*): “*Drug complications were the most common type of adverse event (19%) ...*”

⁷⁴ 3.7% of 21,895 equals 810; 19% of 810 equals 154.

⁷⁵ Institute of Medicine (1999), p.1. (*supra*): “*In Colorado and Utah hospitals, 6.6% of adverse events led to death, as compared with 13.6% in New York hospitals.*”

I have taken the mean of 6.6% and 13.6% (*i.e.* 10.1%) as an estimate.

⁷⁶ Walsh, D. (1999). ‘Letters to the Editor: Deaths in Mental Hospitals.’ *The Irish Times*. 26 Nov.

Appendix J: Pharmaceutical company influence on psychiatric research

The economic importance of the pharmaceutical industry (and of psychiatry to the pharmaceutical industry) is sketched in *Subsection J-1*. Some methods of uncovering pharmaceutical company influence on research results are discussed in *Subsection J-2*; some studies on the pervasiveness of such influence are discussed in *Subsection J-3*. Conclusions are summarised in *Subsection J-4*.

J-1: The financial importance of psychiatry to the pharmaceutical industry

The magnitude of global sales of pharmaceutical products [\$664 billion]¹ gives an indication both of the importance of the pharmaceutical industry to the global economy and of the importance of the key market leading drugs to individual pharmaceutical companies.

The importance of psychiatric pharmaceutical treatments to the global pharmaceutical industry is shown by the fact that of the ten top selling drugs, numbers six, seven and eight were psychiatric treatments; all were atypical antipsychotics² and these three accounted for 23% of the sales of top ten global pharmaceutical products.³

The importance of the pharmaceutical industry to the Irish economy is shown by the fact that it accounted for 40% of exports in 2006;⁴ in that year only two Irish companies

¹ Total global sales of pharmaceutical products in 2007 amounted to \$664 billion of which the top ten products accounted for \$64 billion. IMS Global Healthcare, [online], available: http://www.imshealth.com/deployedfiles/imshealth/Global/Content/StaticFile/Top_Line_Data/Top10GlobalProducts.pdf [accessed: 22 December, 2008].

² *Zyprexa* (olanzapine), *Risperdal* (risperidone) and *Seroquel* (quetiapine).

³ See also Barber(2008):

And today's psychiatry really is corporate. A large proportion, arguably the largest portion, of the major pharmaceutical companies' extraordinary profits in recent decades has come from psychiatric drugs. The medical historian Carl Elliott has written that antidepressants were one of the most profitable products in the most profitable industry in the world over the course of the 1990s.

⁴ Irish Pharmaceutical Healthcare Association (2006), Press release, 19 July:

The industry has made a very significant contribution to the economy with corporate tax payments of over €3 billion annually. The high-value and knowledge-intensive nature of the industry is reflected in the level of exports, which now account for over 40% of total manufacturing exports from Ireland.

[online], available:

<http://www.ipha.ie/htm/mediacentre/download/pressreleases/InnovationForfasReport.pdf> [accessed: 9 February 2009].

were listed in the ‘Forbes Global 500’⁵, one of which – Elan – was a pharmaceutical company.

These figures show the deep interconnection between the pharmaceutical industry and the finance and banking industries and helps explain why the development of new pharmaceutical treatments is often reported on the financial pages of newspapers rather than on those dealing with health.

Elan provides an example of the sensitivity of financial markets not only to the results of drug trials, but to the categorisation of individual adverse events occurring during those trials:

The makers of a promising new drug for multiple sclerosis abruptly pulled it off the market Monday after one patient died of a rare central nervous system disorder. Biogen Idec Inc. and Elan Corp. saw massive drops in their share prices and lost nearly \$18 billion in market value combined.⁶

That such extreme financial consequences could be precipitated by the clinical decision to categorise the death of a single patient as being due to the side effects of a drug rather than to some extraneous cause, clearly makes it difficult to prevent the values of the market place from intruding into clinical research. It is self evident that in the presence of such market volatility, the pharmaceutical industry will seek to exercise its influence both on the reporting of clinical trials (the precondition for drug sales) and on the prescribing of the drugs themselves.

J-2: The uncovering of pharmaceutical company influence

The distortion of psychiatric research by pharmaceutical companies has been revealed principally⁷ through litigation [*J-2(i)*] and the uncovering of previously undisclosed financial links to researchers [*J-2(ii)*].

J-2(i): Drug trial data uncovered during litigation

Of the trial data found to have been withheld, the most relevant to this dissertation concern antidepressants [*J-2(i)(a)*] and antipsychotics [*J-2(i)(b)*].

J-2(i)(a): Antidepressants

Documentation concerning the negative effects of the antidepressant *Paxil* came to light when the New York State attorney general, Eliot Spitzer, sued⁸ the manufacturers

⁵ Finfacts Ireland (2007). ‘R&D Scorecard Global Top 1,000 Companies’. 19 December. [online], available: http://www.finfacts.com/irelandbusinessnews/publish/article_10003718.shtml [accessed: 9 February 2009].

⁶ Girion, L. & Gellene, D. (2005). ‘Patient’s Death Halts New MS Drug.’ *Los Angeles Times*. 1 March. ‘*Tysabri*’ was the drug being tested.

⁷ It has also been revealed by ex-employees and ‘whistle-blowers’; see, for example, Fugh-Berman & Melnick (2008) and Kesselheim (2010).

(GlaxoSmithKline) for withholding data concerning its use in the treatment of adolescent depression. At the time Paxil was the second most widely prescribed antidepressant for children.⁹

The data which had been withheld, had shown that the drug had not only failed to confer any benefit over placebo treatment but had lead to an increase in suicidal ideation. The research paper which had originally been published¹⁰ and which had advocated Paxil for the treatment of adolescent depression, had been ‘ghostwritten’¹¹ and the data had been manipulated to give the impression of efficacy.¹²

J-2(i)(a): Antipsychotics

The documentation concerning the negative effects of the antipsychotic *Zyprexa* came to light during a civil action claiming that the drug’s manufacturers – Lilly – had withheld information about the drugs links to obesity and diabetes.¹³ The plaintiffs made the documents publically available in contravention to the order of the court.¹⁴ Lilly who had been threatened with criminal proceedings, offered \$1billion in addition to \$1.2 billion already paid in settlement of 30,000 lawsuits.¹⁵ The case also highlighted the use of ‘off-label’ marketing.¹⁶

- Antipsychotics prescribed for children

The number of American children and adolescents diagnosed with bipolar disorder increased 40-fold from 1994 to 2003. A report in the *New York Times* stated that:

The children’s treatments almost always included medication. About half received antipsychotic drugs like Risperdal from Janssen or Seroquel from Astrazeneca, both developed to treat schizophrenia.
... The spread of the diagnosis is a boon to drug makers, ...¹⁷

⁸ Harris, G. (2004). ‘Spitzer Sues a Drug Maker, Saying It Hid Negative Data.’ *The New York Times*. 3 June.

⁹ Friedman (2008).

¹⁰ Nine studies on the effectiveness of Paxil had been undertaken but only one had been published. [Keller (2001)].

¹¹ That is it was originally written by the pharmaceutical company and then published under the names of the putative researchers.

¹² Friedman (2008); Grohol (2008) provides links to the original documents.

¹³ See Walsh, M. (2008). ‘Judge to Unseal Documents on the Eli Lilly Drug Zyprexa.’ *The New York Times*. 5 September.

¹⁴ The Court, though giving access to the documents to the plaintiffs’ lawyers, held that they were confidential to the pharmaceutical company and had ordered that they be withheld from the public.

¹⁵ Berenson, A. (2008a). ‘Lilly Considers \$1 Billion Fine to Settle Case.’ *The New York Times*. 31 January.

¹⁶ *Ibid.* Whereas ‘off-label’ prescribing by doctors is legal, off-label marketing by pharmaceutical companies is not.

¹⁷ Carey, B. (2007). ‘Bipolar Illness Soars as a Diagnosis for the Young.’ *The New York Times*. 4 September.

Harris (2008a) noted that: “More than a quarter of the prescriptions for Risperdal were for children and adolescents.”

Harris, G. (2008a). ‘Research Center Tied to Drug Company’, *The New York Times*. 24 November

The health risks associated with the drug are considerable and had been poorly researched.¹⁸

The increase in the diagnoses of bipolar disorder in children is widely credited¹⁹ to Dr. Joseph Biederman²⁰ of Harvard University and one of the most influential researchers in child psychiatry.²¹ Biederman advocated Risperdal for the treatment of childhood bipolar disorder.

A court case between parents of children harmed by Risperdal and the drug's manufacturers [Johnson & Johnson] resulted in the release of emails between Biederman and the manufacturers concerning the financing of a proposed research center:

... with a goal to “*move forward the commercial goals of J. & J.*” ... “*The rationale of this center,*” the message stated, “*is to generate and disseminate data supporting the use of risperidone in*” children and adolescents.”²²

Other emails concerned a study that was to be presented under the name of Biederman, to the American Academy of Child and Adolescent Psychiatry; Dr. Pandina (a company executive) wrote to Biederman:

“*We have generated a review abstract but I must review this longer abstract before passing this along.*” One problem with the study, Dr. Pandina wrote, is that the children given placebos and those given Risperdal both improved significantly. “*So, if you could,*” Dr. Pandina added, “*please give some thought to how to handle this issue if it occurs.*”

The draft ... stated that only the children given Risperdal improved, while those given placebos did not.²³

Commenting on these disclosures a *New York Times* editorial wondered whether Biederman was “... a paid shill for the drug industry.”²⁴

¹⁸ Harris (2008b):

From 1993 through the first three months of 2008, 1,207 children given Risperdal suffered serious problems, including 31 who died. Among the deaths was a 9-year-old with attention deficit problems who suffered a fatal stroke 12 days after starting therapy with Risperdal. At least 11 of the deaths were children whose treatment with Risperdal was unapproved by the F.D.A. Panel members said they had for years been concerned about the effects of Risperdal and similar medicines, but F.D.A. officials said no studies had been done to test the drugs' long-term safety.

Harris, G. (2008b) 'Use of Antipsychotics in Children Is Criticized.' *The New York Times*, 18 November. Also see Harris (2008a): “*Although many of his studies are small and often financed by drug makers, Dr. Biederman has had a vast influence on the field largely because of his position at one of the most prestigious medical institutions.*”

¹⁹ See, for example, Harris (2008b).

²⁰ The findings of the Senate subcommittee concerning undisclosed pharmaceutical company funding to Biederman is discussed *infra*.

²¹ Harris, G & Carey, B. (2008). 'Researchers Fail to Reveal Full Drug Pay.' *The New York Times*. 8 June.

²² Harris (2008a).

²³ *Ibid.*

²⁴ *New York Times* (2008). 'Editorial: Expert or Shill?'. *The New York Times*. 29 November.

J-2(ii): Undisclosed financial links between psychiatrists and pharmaceutical companies

The extent of the financial links between psychiatrists and pharmaceutical companies – though long suspected – were uncovered, in the US, by virtue of the passing of the *Physician Payments Sunshine Act* (2007)²⁵ sponsored by Senators Grassley and Kohl. Prior to these developments two states – Minnesota and Vermont – had required disclosure of pharmaceutical company payments to physicians and this provides an alternative source of data. No comparable system of disclosure exists in the UK²⁶ or Ireland.

Payments fall into two broad categories:²⁷

- inducements offered to individual clinicians with a view to influencing their individual prescribing patterns [*J-2(ii)(a)*];
- payments to academics and researchers which may influence research results [*J-2(ii)(b)*].

J-2(ii)(a): Individual inducements

Although most physicians deny that receiving free lunches, subsidized trips, or other gifts from pharmaceutical companies has any effect on their practices, Campbell (2008) oppugns the validity of such claims, by asking:

After all, if these relationships didn't affect physician behavior in such a way as to increase sales, companies wouldn't spend \$19 billion each year establishing and maintaining them.²⁸

In relation to psychiatry, the Senate subcommittee: "... *found an orchard of low-hanging fruit.*"²⁹ Though psychiatrists earn less in base salary than any other specialists, their total remuneration tops all others when consulting arrangements are taken into account.³⁰ In Vermont, for example:

²⁵ So named because it aims to "... *shine a much needed ray of sunlight on a situation that contributes to the exorbitant cost of health care*". [Campbell (2007), p.1796]

²⁶ Where pharmaceutical company payments to doctors have been described as being "... *far from transparent.*" [See Boseley, S. & Evans, R. (2008). 'Drug giants accused over doctors' perks'. *The Guardian*. 23 August.].

²⁷ Payment have also been made to patient advocacy groups, see, for example, Harris (2009):

Earlier this year, Mr. Grassley sent a similar letter to the National Alliance on Mental Illness. In response, the group told the senator that more than two-thirds of its donations come from the pharmaceutical industry.

Harris, G. (2009). 'Senator Grassley Seeks Financial Details From Medical Groups.' *The New York Times*. 7 December.

²⁸ Campbell (2007), p.1796.

²⁹ Carey, B. & Harris, G. (2008) 'Psychiatric Group Faces Scrutiny Over Drug Industry Ties' *The New York Times*. 12 July.

³⁰ *Ibid.*

... psychiatrists earn more money from drug makers than doctors in any other specialty. ... the more psychiatrists have earned from drug makers, the more they have prescribed a new class of powerful medicines known as atypical antipsychotics to children, for whom the drugs are especially risky and mostly unapproved.³¹

An analysis of data from Minnesota yielded similar conclusions.³²

An indicator of the amount of money involved can be gleaned from the fact that "... more than 250 Minnesota psychiatrists together earned \$6.7 million in drug company money — more than any other specialty."³³ and from payments to a psychiatrist member of a Minnesota Drug Formulary Committee who had earned more than \$350,000 from Eli Lilly and AstraZeneca between 2004 and 2006 in honoraria, speaker's and consulting fees,³⁴ though he denied that his clinical decisions had been influenced.³⁵

In assessing the effect of such undeclared payments, an analogy might be provided by considering the case of a judge, who having decided a court case, was found to have received payments from an interested party. An appropriate rule in such situations, is to the effect that even where there is an absence of direct evidence that gifts influenced a decision, the fact that a gift is undeclared is sufficient to 'shift the burden of proof' and to warrant the conclusion that verdicts are to be regarded as tainted unless the contrary be clearly proved.³⁶

The application of such a rule to undeclared pharmaceutical contributions to clinical and research psychiatrists would imply that all such contributions should be regarded as tainting any research or other decision unless and until the contrary be proved.

J-2(ii)(b): Financial links to academics and researchers

The Senate subcommittee investigations proceeded by way of obtaining details from the pharmaceutical companies, as to their payments to individual psychiatrists and then comparing this data with the declarations of funding made by the psychiatrists themselves either to their universities or to academic journals when submitting articles for publication; two examples are given:

- Dr. Biederman (*supra*) a psychiatrist at Harvard University;

³¹ Harris, G. (2007). 'Psychiatrists Top List in Drug Maker Gifts.' *The New York Times*. 27 June.

³² *Ibid.*

³³ Harris, G. & Roberts, J. (2007). 'Doctors' Ties to Drug Makers Are Put on Close View.' *The New York Times*. 21 March.

³⁴ Lohn, M. (2007). 'Minn. Law Sheds Light on Drug Companies.' *The Washington Post*. 21 August.

³⁵ Yet, as noted by Lohn, (2007): "*The top drugs for Minnesota Medicaid patients covered by the panel's advice in recent years have been schizophrenia treatments from Eli Lilly & Co. and AstraZeneca ...*"

³⁶ See, for example, Urbina, I. & Hamill, S. (2009). 'Judges Plead Guilty in Scheme to Jail Youths for Profit.' *The New York Times*. 12 February.

- Dr. Nemeroff, a psychiatrist at Emory University.

A further example concerns undeclared payments to a prominent media psychiatrist (Dr. Goodwin) and the final example details financial links between the pharmaceutical industry and the American Psychiatric Association.

- Biederman³⁷

Since the mid 1990s Biederman (*supra*) promoted the aggressive diagnosis of childhood bipolar disorder and advocated the use of antipsychotics in its treatment. In 2008, Senator Grassley reported that:

Biederman, a renowned child psychiatrist at Harvard Medical School, and a colleague ... had reported to university officials earning several hundred thousand dollars each in consulting fees from drug makers from 2000 to 2007, when in fact they had earned at least \$1.6 million each. ... Another member of the Harvard group ... reported earning at least \$1 million after being pressed by Mr. Grassley's investigators.³⁸

- Nemeroff

Nemeroff who has been described as “*one of the nation’s most influential research psychiatrists*”,³⁹ was editor of *Neuropsychopharmacology* which had printed a review of a device for the treatment for depression⁴⁰ but had omitted to reveal the financial ties of the reviewer – and of the editor – to the company (Cyberonics) marketing the device. Because the device’s licensing by the FDA had been controversial:⁴¹

³⁷ See the earlier discussion on documents released during litigation which evidenced the nature of the relationship between Biederman and the makers of an antipsychotic drug used in the treatment of childhood bipolar disorder.

³⁸ Carey & Harris (2008) *supra*.

³⁹ Carey, B. (2006). ‘Correcting the Errors of Disclosure.’ *The New York Times*. 25 July.

⁴⁰ The ‘*vagus nerve stimulator*’ is a device surgically implanted in the upper chest which stimulates a nerve leading to the brain.

⁴¹ Carey (2006):

The treatment ... was approved for depression in 2005 after intense debate over its effectiveness. ... In a bitter debate over the interpretation of these results, more than 20 experts at the Food and Drug Administration opposed the approval of the device for depression before being overruled by a senior official, according to a Senate Finance Committee investigation.

Even though the vagus nerve stimulator had been shown to be no more effective than a placebo as a treatment for depression, its proponents had urged that it should be licensed as a treatment for patients whose depression had previously proved intractable. An advisory panel having heard testimonials from a number of patients, approved the device; its chairwoman Dr. Kyra Becker stated “*The feeling was that anything that gives these people hope is potentially worthwhile.*”

[Carey, B. (2005) ‘F.D.A. Considers Implant Device for Depression.’ *The New York Times*. 21 May.].

A later report gives an indication of the magnitude of the financial interests involved:

... more than 550 Americans have undergone surgery to have a vagus nerve stimulator (VNS) implanted ... Another 7,000 people ... are seeking approval from their insurance companies for the \$25,000 operation. More than 3,700 psychiatrists ... have been trained in the use of VNS, ...

[Boodman S. (2006). ‘Mood Machine: Now There’s a Device to Treat Depression. If Only There Were Solid Evidence That It Works’. *Washington Post*, 21 March.]

The device begged for some more public analysis. But few if any outside experts knew the data well enough to raise questions. And the scientists who did know the science and the data were all on the company's payroll.⁴²

The publication of the review was criticised by Emory University, its associate dean stating: *"I can't believe that anyone in the public or in academia would believe anything except that this paper was a piece of paid marketing."*⁴³

Letters written by Nemeroff to the university which surfaced during congressional hearings shows that the university itself was not a disinterested party:

"Surely you remember that Smith-Kline Beecham Pharmaceuticals donated an endowed chair to the department and that there is some reasonable likelihood that Janssen Pharmaceuticals will do so as well," he wrote.

*"In addition, Wyeth-Ayerst Pharmaceuticals has funded [an] ... Award program in the department, and I have asked both AstraZeneca Pharmaceuticals and Bristol-Meyers [sic] Squibb to do the same."*⁴⁴

In 2008, Senator Grassley revealed that Nemeroff:

... earned more than \$2.8 million in consulting arrangements with drugmakers from 2000 to 2007, failed to report at least \$1.2 million of that income to his university and violated federal research rules.⁴⁵

- *Goodwin*

Dr. Goodwin, a psychiatrist who had written an influential textbook on bipolar disorder and was an adjunct professor at George Washington University, had hosted a prestigious US National Public Radio programme⁴⁶ which had:

... more than one million listeners in more than 300 radio markets. The program has received major underwriting from the National Institutes of Health and the National Science Foundation ...⁴⁷

Goodwin had earned at least \$1.3 million from 2000 to 2007 giving marketing lectures for drugmakers, income not mentioned on the program, nor declared to his employers.⁴⁸

His weekly radio programs had often touched on subjects important to the commercial interests of the companies for which he consulted:

... he warned that children with bipolar disorder who were left untreated could suffer brain damage, a controversial view. *"But as we'll be hearing today,"* Dr.

⁴² Carey (2006) *supra*.

⁴³ Harris, G. (2008c). 'Top Psychiatrist Didn't Report Drug Makers' Pay.' *The New York Times*. 3 October.

⁴⁴ *Ibid*.

⁴⁵ Harris, G. (2008d). 'Drugmakers Paid Radio Host \$1.3 Million for Lectures.' *The New York Times*. 22 November.

⁴⁶ Harris (2008d): *"The Infinite Mind" has won more than 60 journalism awards over 10 years and bills itself as "public radio's most honored and listened to health and science program."*

⁴⁷ *Ibid*.

⁴⁸ *Ibid*: *"The fact that he was out on the stump for pharmaceutical companies was not something we were aware of, ... It would have violated our agreements."*

Goodwin told his audience, "*modern treatments – mood stabilizers in particular – have been proven both safe and effective in bipolar children.*" That same day, GlaxoSmithKline paid Dr. Goodwin \$2,500 to give a promotional lecture for its mood stabilizer drug, Lamictal, ... In all, GlaxoSmithKline paid him more than \$329,000 that year for promoting Lamictal, records given to Congressional investigators show.⁴⁹

- *The American Psychiatric Association (APA)*

The APA, in response to a request⁵⁰ from Senator Grassley's subcommittee, reported that pharmaceutical companies provided about 30% of its \$62.5 million in revenues in 2006, the most recent year for which financial data were available.⁵¹

The APA is the publisher of the *Diagnostic and Statistical Manual of Mental Disorders* (the 'DSM') which is currently in its fourth edition with the fifth edition in the consultative stage.⁵² The proposal of new categories of illness – e.g. 'hypersexuality', 'binge eating' – are clearly of interest to the pharmaceutical industry in that the treatment of such proposed categories may provide an additional use for an existing or planned pharmaceutical product; the term '*disease mongering*' has been coined to describe the proactive role taken by pharmaceutical companies in the creation of diseases for which they anticipate being able to provide treatment.⁵³

In such circumstances, it is self-evident that the influence of the pharmaceutical companies on the consultative panels needs to be minimised⁵⁴ and to that end the psychiatrists working on such panels "*agreed to limit their income from drug makers and other sources to \$10,000 a year for the duration of the job.*"⁵⁵ In view of the magnitude of the financial interests involved, this appears to be a less than onerous burden.

⁴⁹ *Ibid.*

⁵⁰ The request stated: "*I have come to understand that money from the pharmaceutical industry can shape the practices of nonprofit organizations that purport to be independent ...*" [Carey & Harris (2008) *supra*].

⁵¹ *Ibid.*

⁵² See the discussion on the *DSM-V* [draft] in Chapter 4.

⁵³ See, for example, Moynihan (2002) and Kumar (2006).

⁵⁴ See, for example, *New York Times* editorial:

The pharmaceutical industry, in particular, doles out lots of money to doctors and academic experts in the form of speaking fees, consultancies, research grants and other financial benefits. And many of these recipients end up on federal advisory committees.

... In one egregious example, a panel that favored marketing the controversial painkillers Bextra and Vioxx would have made the opposite recommendation if the experts with industry ties had been excluded from voting.

The New York Times (2007) 'Editorial: A Cleaner Food and Drug Agency.' *The New York Times*. 23 March

⁵⁵ Carey, B. (2008). 'Psychiatrists Revise the Book of Human Troubles.' *The New York Times*. 17 December.

Cosgrove (2006), noting that no earlier study had been made of the financial links between pharmaceutical companies and advisory panel members, examined the financial links of panel members involved in the *DSM-IV* process and concluded that:

The connections are especially strong in those diagnostic areas where drugs are the first line of treatment for mental disorders. ... 100% of the members of the panels on 'Mood Disorders' and 'Schizophrenia and Other Psychotic Disorders' had financial ties to drug companies.⁵⁶

It was not within the ambit of the study to determine whether these interests had been declared nor whether they had constituted a conflict of interest.

J-3: The pervasiveness of pharmaceutical industry influence on medical research.

Lest it be imagined that the above examples were unrepresentative, editorials from leading medical journals also attest to the corrosive influence of the pharmaceutical industry on both medical research and its reporting: a *Journal of the American Medical Association* editorial is quoted in J-3(i); a *New England Journal of Medicine*, in J-3(ii); a *British Medical Journal* J-3(iii) and an *American Journal of Psychiatry*, in J-3(iv).

J-3(i): Journal of the American Medical Association

An editorial entitled "*Impugning the Integrity of Medical Science: The Adverse Effects of Industry Influence*" began:

The profession of medicine, in every aspect – clinical, education, and research – has been inundated with profound influence from the pharmaceutical and medical device industries. This has occurred because physicians have allowed it to happen, and it is time to stop.⁵⁷

The editorial then discussed two articles published in that issue of the journal which detailed how in the marketing of its drug Vioxx, the manufacturers (Merck), in submissions to the FDA, misrepresented the mortality risk of the drug;⁵⁸ and how it "... *apparently manipulated dozens of publications to promote one of its products.*"⁵⁹ One of the articles illustrated how clinical trial articles and review articles had been 'ghost-written' and their authorship attributed: "... *to academically affiliated investigators who either had little to do with the study or review or who did not disclose financial support from the company.*"⁶⁰ The editorial clearly regards Merck's behaviour as not being

⁵⁶ Cosgrove (2006), p.154.

⁵⁷ DeAngelis & Fontanarosa (2008), p.1833.

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

unusual: “*But make no mistake – the manipulation of study results, authors, editors, and reviewers is not the sole purview of one company.*”⁶¹

J-3(ii): The New England Journal of Medicine

An editorial entitled “*Is Academic Medicine for Sale?*” recounts how the journal wished to commission an editorialist to review an article on antidepressants, but found very few who did not have a possible conflict of interest:

The ties between clinical researchers and industry include not only grant support, but also a host of other financial arrangements. Researchers serve as consultants to companies whose products they are studying, join advisory boards ... agree to be the listed authors of articles ghostwritten by interested companies, promote drugs and devices at company-sponsored symposiums, and allow themselves to be plied with expensive gifts and trips to luxurious settings. Many also have equity interest in the companies.⁶²

The editorial went on to note that academic medical institutions are also compromised.

J-3(iii): British Medical Journal (BMJ)

The *BMJ* dedicated a full issue⁶³ to the topic of pharmaceutical industry influence with an editorial asking:

How did we reach the point where doctors expect their information, research, education, professional organisations, and attendance at conferences to be underwritten by drug companies?⁶⁴

In support, it referred to research which found that “... *studies sponsored by pharmaceutical companies are four times as likely to have outcomes favouring the sponsor than are studies funded by other sources*”.⁶⁵

A 2005 editorial revisited the same issues and referred to a House of Commons report⁶⁶ on the influence of the pharmaceutical industry, which:

... found an industry that buys influence over doctors, charities, patient groups, journalists, and politicians, and whose regulation is sometimes weak or ambiguous. ... Over half of all postgraduate medical education in the UK, and

⁶¹ *Ibid.*

See also: Associated Press (2006). ‘Medical Journal Says It Was Again Misled’. *The New York Times*. 13 July:

For the second time in two months, The *Journal of the American Medical Association* says it was misled by researchers who failed to reveal financial ties to drug companies. ... The latest incident ... involves a study showing that pregnant women who stop taking antidepressants risk slipping back into depression. Most of the 13 authors have financial ties to drug companies including antidepressant makers, but only two of them revealed their ties when the study was published in February. Antidepressant use during pregnancy is controversial, and some studies have suggested that the drugs could pose risks to the fetus.

⁶² Angell (2000), p.1516.

⁶³ *British Medical Journal* (2003); 326: 7400, entitled “*Time to untangle doctors from drug companies.*”

⁶⁴ Abbasi & Smith (2003).

⁶⁵ *Ibid.*, citing Lexchin (2003).

⁶⁶ House of Commons Health Committee (2005).

much education of nurses, is funded by the pharmaceutical industry from its annual marketing budget of £1.65bn.⁶⁷

The conclusions of the House of Commons report were mirrored those of an Oireachtas Joint Committee on Health and Children (2007) which also made some trenchant criticism of the pharmaceutical industry especially in relation to psychiatric drugs.⁶⁸

J-3(iv): The American Journal of Psychiatry (AJP)

Although the *AJP* has published editorials⁶⁹ on conflicts of interest, which noted failures in relation to academic psychiatry, these were – in contrast to the journals discussed above – essentially aspirational in tenor and curiously reticent about other possible examples of misconduct of which there appeared to be no shortage in academic and research psychiatry: for example, a study⁷⁰ which had been published in the journal but a year earlier and which was “*one of the first recent examinations of conflict of interest specifically in the psychiatric literature*”⁷¹ had found:

Results: Among 397 clinical trials identified, ...60% reported receiving funding from a pharmaceutical company ... and ... 47% included at least one author with a reported financial conflict of interest.

... those that reported conflict of interest were 4.9 times more likely to report positive results;

Conclusions: Author conflict of interest appears to be prevalent among psychiatric clinical trials and to be associated with a greater likelihood of reporting a drug to be superior to placebo.⁷²

The reticence of the *AJP* stands in stark contrast to the observations of Tim Kendall, deputy director of the Royal College of Psychiatrists' Research Unit:

In mental health 85% of all published trials are funded by the drug industry, ... Allowing for the unsuccessful trials the industry does not publish, the figure is probably nearer 95%.⁷³

The above discussion related to the influence of the pharmaceutical industry on researchers and academics, but it has also been suggested that both academic journals themselves⁷⁴ and the FDA⁷⁵ have also been compromised.

⁶⁷ Ferner (2005).

⁶⁸ See Appendix I (*supra*).

⁶⁹ For example, Lewis (2006) and Freedman (2006).

⁷⁰ Perlis (2005).

⁷¹ *Ibid.*, p.1959.

⁷² *Op. cit.*, p.1957.

⁷³ Quoted in Boseley, S. (2009). 'British doctor faces action over claims of 'ghost writing' for US drug company.' *The Guardian*. 18 September.

⁷⁴ See Smith (2006); Smith, who was a former editor of the *British Medical Journal*, relates how the *New England Journal of Medicine* was compromised in its reporting of both the original Vioxx study and subsequent evidence that the original Vioxx data had been incomplete. He details how the owners of the journal had “... grown fat on the profits and is keen not only to keep the profits coming but also to exploit

J-4: Summary of methods used to exert influence

Listed below is a summary of some of the mechanisms – many of which have been mentioned in earlier discussion – which have been used by the pharmaceutical industry to exert influence on both psychiatric research and academic and clinical psychiatry:

- design of drug tests;
- commissioning of drug tests;
- selective reporting of results of drug tests;
- ‘targeting’ of academic critics;⁷⁶
- non-performance of follow-on tests;⁷⁷
- non-proactive monitoring of side-effects;
- ghostwriting of journals articles;⁷⁸
- influence of academic journals;⁷⁹
- influence on diagnostic editorial committees;
- ‘disease mongering’;
- publication bias;
- influence on academics;

the brand.” which lead to conflicts with two editors who resigned and subsequently “*published books bemoaning the excessive influence of the drug industry*”.

⁷⁵ A report issued by the Institute of Medicine on the FDA stated:

“Some also have serious concerns that the regulator has been ‘captured’ by industry it regulates, that the agency is less willing to use the regulatory authority at its disposal,” the report said, criticizing the agency’s regulatory tools as “*all-or-nothing*.”

See Harris, G. (2006). ‘Study Condemns F.D.A.’s Handling of Drug Safety’. *The New York Times*. 23 September.

See also Shuchman (2007) who details the controversy surrounding the licensing by the FDA of the vagus nerve stimulator (*supra*).

⁷⁶ Marks & Verkaik (2010):

Merck also drew up a “hit list” of doctors and academics who needed to be “neutralised” or “discredited”, according to company emails, because they had criticised the drug. It paid nurses to rifle patient records for potential candidates for Vioxx, and it persuaded the world’s largest medical publisher, Elsevier, to produce several issues of what appeared to be an independent scientific journal, without disclosing that it was funded by Merck.

Marks K. & Verkaik, R. (2010). ‘Vioxx ruling gives hope for payouts to British ‘victims’’. *The Independent*. 6 March.

⁷⁷ *I.e.* further tests which had been requested by the regulator at the time of approval but which were never completed. See, for example, Perrone (2009):

The Food and Drug Administration ... has never pulled a drug off the market due to a lack of required follow-up about its actual benefits – even when such information is more than a decade overdue, according to a report due out Monday from the Government Accountability Office.

Perrone, M. (2009). ‘GAO: FDA fails to follow up on unproven drugs.’ *The Washington Times*. 26 October.

⁷⁸ See *supra* and also, for example, Boseley (2009):

The General Medical Council will call Professor Richard Eastell in front of a fitness to practice committee. Eastell, a bone expert at Sheffield University, has admitted he allowed his name to go forward as first author of a study on an osteoporosis drug even though he did not have access to all the data on which the study’s conclusions were based. An employee of Proctor and Gamble, the US company making Actonel, was the only author who had all the figures.

⁷⁹ See, for example, Marks & Verkaik (2010) (*supra*).

- influence on academic institutions;
- sponsorship of undergraduate and postgraduate psychiatric education;
- influence on drug regulators;
- influence on formulary committees;
- influence on clinical psychiatrists;
- payments to clinical psychiatrists;⁸⁰
- off-label promotion;⁸¹
- sponsorship of professional meetings;
- funding of patient advocacy groups;
- media consumer advertising;
- ‘gag-orders’ against disclosure;⁸²
- other exercise of economic power.

⁸⁰ Harris (2009) details a pharmaceutical company’s antidepressant drug marketing plan which had been made public during Senate subcommittee investigations:

It is illegal to pay doctors to prescribe certain medicines to their patients. It is not illegal to pay doctors to educate their colleagues about a medicine. In recent years, federal prosecutors have accused many drug makers of deliberately crossing that line. ... Under “*Rep Promotional Programs*,” the document said the company planned to spend \$34.7 million to pay 2,000 psychiatrists and primary care doctors to deliver 15,000 marketing lectures to their peers in one year. “*These meetings may be large-scale dinner programs with a slide presentation, small roundtable discussions or one-on-one advocate lunches*,” the document states. ... Under “*Lunch and Learns*,” the company intended to spend \$36 million providing lunch to doctors in their offices.

Harris, G. (2009). ‘Document Details Plan to Promote Costly Drug.’ *The New York Times*. 1 September. A *New York Times* report details how a pharmaceutical company was fined \$81 million for illegally promoting an epilepsy drug for psychiatric uses:

... under a program called Doctor-for-a-Day. The program hired outside physicians who joined sales representatives in visits to health care providers ... about prescribing Topamax for unapproved uses.

Associated Press (2010), ‘Drug Makers to Pay Fine of \$81 Million.’ *The New York Times*. 29 April.

⁸¹ The extent of the profits to be gained from off-label promotion are indicated by the fact that fines of \$1.9 billion levied of Pfizer were still not a sufficient deterrence:

For this new felony, Pfizer paid the largest criminal fine in U.S. history: \$1.19 billion. On the same day, it paid \$1 billion to settle civil cases involving the off-label promotion of Bextra and three other drugs with the United States and 49 states. “*At the very same time Pfizer was in our office negotiating and resolving the allegations of criminal conduct in 2004, Pfizer was itself in its other operations violating those very same laws*,” ...

The total of \$2.75 billion Pfizer has paid in off-label penalties since 2004 is a little more than 1% of the company’s revenue of \$245 billion from 2004 to 2008.

Evans, D. (2010). ‘When drug makers’ profits outweigh penalties.’ *The Washington Post*. 21 March.

⁸² Hari (2009):

In 1996, Dr. Nancy Olivieri was commissioned at her university to study a drug developed by Apotex Inc that treats a rare blood disorder. She discovered a serious side-effect. When she tried to inform her patients, the company brought the study to a sudden halt, and told Dr Olivieri that she could be sued.

Hari, J. (2009). ‘Peter Mandelson’s assault on science.’ *The Independent*. 17 November.

Based on the preceding discussion the following conclusion can be drawn:

The influence of the pharmaceutical industry on the nature, conduct and reporting of psychiatric research is pervasive, often hidden, and is of such a magnitude as to cast doubt on the impartiality, objectivity and evidence base of much published research. Consequently individual psychiatric research studies on matters touching on the interests of the pharmaceutical industry and which purport to be objective and evidence-based, should not be regarded as such unless their independence from such interests, can be explicitly demonstrated.

Appendix K: Problematic aspects of antidepressant research

Note: As mentioned at the commencement of Chapter 5, the discussion of psychiatric treatments in this Appendix is not intended to provide a comprehensive, objective and balanced overview of research into antidepressants. The goal is much more circumscribed: it is – by examining the published work of academic commentators and researchers in this area – to establish a *prima facie* case that clinical psychiatric practice in the use of antidepressants, often lacks (and, on occasion, conflicts with) a robust evidence-base.

Doubts as to the validity of clinical trials of antidepressants had, by the late 1990s, become prevalent and led the *American Journal of Psychiatry* to commission a study [Quitkin (2000)] to examine the evidence cited for assertions that:

... antidepressants are no better than placebo treatment and that their illusory superiority depends on methodologically flawed studies and biased clinical evaluations.
... that the blind in randomized trials is penetrable.¹

The authors concluded that:

... studies cited as supporting the questionable validity of antidepressant trials fail upon closer examination to support assertions that these trials are invalid.²

A subsequent editorial in the *British Journal of Psychiatry* adopted a more nuanced perspective:

Adverse physical effects of antidepressant treatment are well known, but the psychological effects are rarely discussed. The prescription of medication for depression conveys the powerful message that we are passive victims of our biology. ... The pharmaceutical industry is an obvious beneficiary of this situation and psychiatry must be wary of being swept along by this juggernaut. ... it is necessary at least to raise questions about the efficacy of antidepressants.³

A response was subsequently published which stated:

The efficacy argument at the head of her critique, based on individual, often old and poor-quality, studies flies in the face of consistent findings of antidepressant efficacy in systematic reviews and meta-analyses.⁴

Some clarity and focus was brought to the debate by Kirsch (2002) who under a 'Freedom of Information' request, obtained :

... the medical and statistical reviews of every placebo controlled clinical trial for depression reported to the FDA for initial approval of the six most widely used antidepressant drugs approved [between 1987 and 1999].

¹ *Op. cit.*, p.327.

² Quitkin (2000), p.327.

Quitkin appends no declaration of interests to his article, yet in a subsequent letter to the *British Medical Journal* [Quitkin (2005)] he declares numerous competing interests. These interests may, of course, have arisen post 2000.

³ Moncrieff (2002), p.194.

⁴ Anderson & Haddad (2003).

An analysis of the data revealed:

... a small but significant difference between antidepressant drug and inert placebo. ... its clinical significance is dubious ...⁵

Kirsch (2002) also noted that the criteria used by the FDA in approving antidepressant medications required “*positive findings from at least two controlled clinical trials, but the total number of trials can vary.*”⁶ The implementation of this criterion had the surprising consequence that if two positive trials existed, other negative trials may be disregarded even if these had been more numerous.⁷

Antonuccio (2002), commenting on Kirsch (2002), posed a rhetorical question:

Does the small advantage of antidepressants over placebo justify the risks and side effects associated with these medications? How have we come to think of antidepressants as powerful, even “*life-saving*” treatments in the face of such weak outcome data?

The title to his article – “*Antidepressants: A Triumph of Marketing Over Science?*” – suggested his answer.⁸

Evidence subsequently began to emerge not only as to the lack of effectiveness of antidepressants, but as to their lack of safety. Parker (2003) opined that the then recent warnings that the dangers of treatment of adolescent depression with SSRI’s⁹ outweighed the benefits, “... *should focus our minds on the evidence on which clinical practice is based.*” Noting that “*about 50% of negative trials go unpublished,*” Parker (2003) wondered whether such clinical trials should be abandoned because they “*are producing meaningless results.*” In view of studies such as Quitkin (2000) (*supra*), the simple posing of this question is worthy of note.

A further milestone occurred with the publication of Whittington (2004). Having noted inconsistencies between the published studies and the advice of regulatory agencies in relation to the use of SSRIs in the treatment of adolescent depression, Whittington (2004): “... *contacted all the pharmaceutical companies who manufacture antidepressants requesting unpublished data. None was forthcoming.*”¹⁰ The authors then obtained details of the trials which had been submitted to the regulatory agencies.

⁵ Kirsch (2002); the first usage of the term ‘significant’ refers to statistical significance.

⁶ *Ibid.*

⁷ Kirsch (2002) gives examples of such occurrences.

⁸ It should be noted that the Kirsch (2002) meta-analysis has been criticized on methodological grounds by Cipriani (2009) and that other meta-analyses – such as Melander (2008) and Khan & Khan (2008) – have reached conclusions different to Kirsch (2002).

⁹ Selective Serotonin Reuptake Inhibitors [SSRIs] are antidepressants; examples are *Seroxat* and *Paxil*.

¹⁰ *Op. cit.*, p.1345.

The authors concluded that, though the published studies indicated that the medications were safe and effective: “*When we got the unpublished data and put it in with the published data, something happened. Instead of being safe and effective, the risk-benefit reversed.*”¹¹ An accompanying editorial commented:

The idea of that drug's use being based on the selective reporting of favourable research should be unimaginable. ... where evidence-based practice is seen as the gold standard for care, these failings are a disaster. ... This process is made entirely redundant if its results are so easily manipulated by those with potentially massive financial gains.¹²

The philosopher Simon Blackburn has spoken of how the pharmaceutical industry has “... led to the institutional corruption of science by the billions involved in the manufacture and selling of drugs.”¹³ In support, he cited the questioning of the FDA by a US congressional sub-committee:

... who pointed out that nearly all studies of antidepressants in children and teenagers had failed to show that they were effective for depression. With no benefit to recommend them and a risk for suicidal behaviour the members said that they could not understand why the agency did not ban the drugs.¹⁴

The director of the FDA had responded:

... that just because the trials had failed to show an effect did not mean that the medications were not working. “*More than 50% of all trials in adults fail too*” he said. “*We don't know why*”.¹⁵

To which Blackburn commented “*I find that pretty scary as well.*”¹⁶

The focus was beginning to shift towards a scrutiny of the evidence base for the adult use of antidepressants.

¹¹ Kendall, joint author of Whittington (2004) in an interview to the *New Scientist*. [online], available: <http://www.newscientist.com/article/dn4920-unpublished-data-reverses-riskbenefit-of-drugs.html> [accessed: 2 March 2009].

He also stated that:

Of the five SSRIs reviewed - fluoxetine, paroxetine, sertraline, citalopram, and venlafaxine, only fluoxetine (Prozac) offers more benefits than risks in children. Unpublished studies of venlafaxine, for example, suggested the drug increased suicide-related events such as suicidal thoughts or attempts by 14 times compared with placebo.

"This data confirms what we found in adults with mild to moderate depression: SSRIs are no better than placebo, and there is no point in using something that increases the risk of suicide," says Kendall. "The key point is, can we trust the published evidence now?"

¹² Lancet (2004) which commented:

It is hard to imagine the anguish experienced by the parents, relatives, and friends of a child who has taken his or her own life. That such an event could be precipitated by a supposedly beneficial drug is a catastrophe.

¹³ Blackburn, S. (2004). Lecture entitled ‘*Trust me I'm a Scientist*’ given to a Cambridge Philosophy Society on 23 September.

¹⁴ Harris, G. (2004). ‘Warnings Called Likely On Drug Risk For Suicide.’ *The New York Times*. 24 September.

¹⁵ *Ibid.*

¹⁶ *Op. cit.*

In 2004 the National Institute for Clinical Excellence issued guidelines [NICE (2004a)] on the pharmaceutical treatment of adult depression and recommended that SSRIs be “*first line treatment for moderate or severe depression.*”¹⁷

Moncrieff & Kirsch (2005) argued that the data on which the guidelines had been based, did not support the recommendation:

... methodological artefacts may account for the small effect seen. ... In children, the balance of benefits to risks is now recognised as unfavourable. We suggest this may also be the case for adults, given the continuing uncertainty about the possible risk of increased suicidality as well as other known adverse effects.¹⁸

The House of Commons Health Committee (2005) addressed the use of SSRIs as a treatment for adult depression; it found that – although there had been long-standing concerns that the drugs were addictive¹⁹ and could induce “*suicidal and violent behaviour*”²⁰ – the clinical trials of SSRIs “... *were not adequately scrutinised ... [and] have been indiscriminately prescribed on a grand scale.*”²¹ The report stated that although SSRIs, had been licensed for 15 years and in spite of several earlier reviews of the same drug problems, the UK regulatory agency “*had received no convincing evidence*” relating to efficiency in mild depression nor or the incidence of withdrawal reactions.²²

The poor reliability of published research into the efficacy of antidepressants was addressed by Turner (2008)²³ who found that although an analysis of published data suggested that 94% of the trials conducted were positive, the inclusion of unpublished data, reduced this to 51%.

The Kirsch (2008) study was a meta-analysis of four new-generation antidepressants for which full datasets were available and found that:

¹⁷ Moncrieff & Kirsch (2005), p.155.

¹⁸ *Op. cit.*, p.157.

¹⁹ *Op. cit.*, p.85: “...*some users found it impossible to stop taking SSRIs because of severe withdrawal symptoms.*”

²⁰ *Ibid.*

²¹ *Ibid.*, p.100. [Emphasis in original].

²² *Ibid.*, p.79.

The report quoted (p.83) evidence from Professor Healy that “*In actual fact here in the UK we track the fate of parcels through the post one hundred times more accurately than you track the fate of people who have been killed by SSRI or other drugs.*”

It also quoted (p. 54) the evidence the editor of *The Lancet*:

... this whole story surrounding SSRIs ... is probably the best example where the companies have been very clever at seeding the literature with ghost-written editorials and review papers that promote off-label use of these drugs ... that is how you had two and a half million scripts a couple of years ago for SSRIs in under-18s with no licensed indication for it.

²³ Appendix J *supra*.

... the researchers conclude that there is little reason to prescribe new-generation antidepressant medications to any but the most severely depressed patients unless alternative treatments have been ineffective.²⁴

Mathew & Charney (2009) writing in the *American Journal of Psychiatry*, addressed Kirsch's (2008) and Turner's (2008) conclusions:

The first study contends that publication bias ... results in an inaccurate characterization of antidepressant efficacy, while the second study argues that even when registration trials are positive, antidepressant efficacy is modest and of doubtful clinical significance. Although these reports offer a sober perspective on the benefit of our most commonly prescribed antidepressant medications, the trials suffer from poor generalizability to "real-world" patients.²⁵

Mathew & Charney (2009) then discussed the results of the STAR*D trial which had been designed to have more clinical relevance than trials designed to satisfy the requirements of licensing authorities:

... the landmark NIMH-funded STAR*D trial examined the acute and longer-term effectiveness of antidepressants and augmentation strategies (including cognitive therapy) ... Although the acute and longer-term remission rates were disappointing, patients who completed all phases of the study had an overall cumulative remission rate of 67%.²⁶

A summary of the results of the STAR*D trial in *The Lancet* was more critical:

"STAR*D showed that virtually all antidepressant strategies had low and similar efficacy in major depression."²⁷ Cipriani (2009) [discussed *supra*] reviewed all trials of second-generation antidepressants performed before 2007 and rated them as "... adequate, unclear, or inadequate, according to the adequacy of the random allocation concealment and blinding."²⁸

Of a total of 117 trials only 12 were rated as adequate.

At the beginning of this appendix a special article commissioned by the *American Journal of Psychiatry* was cited to the effect that criticisms of antidepressants trials could not be substantiated. Less than a decade later, a highly regarded²⁹ study [Cipriani(2009)] which was free of pharmaceutical industry funding, found that the methodology of more than 89.7% of all 117 trials on antidepressants conducted in the previous 16 years, to be less than adequate.

Cipriani (2009) also found that the design of the trials (being as they were of short duration) rendered the results of limited use in clinical psychiatric practice. The limited

²⁴ Kirsch (2008), p.268.

²⁵ *Op. cit.*, p.140.

²⁶ *Ibid.*

²⁷ Parikh (2009), p.700.

²⁸ Cipriani (2009), p.747.

²⁹ See Parikh (2009) (*supra*).

duration of trials would have the effect of minimising the perceived side effects of medications. Cipriani (2009) did not investigate either the nature or incidence of such harms.³⁰ Where clear evidence of harms did materialise – as in the case of the pharmaceutical treatment of adolescent depression (*supra*) – clinicians appear to have adopted a somewhat cavalier attitude to evidence of such harm as evidenced by the answer to a British parliamentary question which elicited the information that in 2006, one in three antidepressants prescribed for children are prescribed against the advice of the regulatory authority.³¹

Dr. Andrew Nierenberg, an associate professor of psychiatry at Harvard Medical School interviewed by the *New York Times* – and described as having “*consulted with drug makers*”³² – was reported as responding to an FDA warning on the prescribing of antidepressants for adolescent depression:

... that he did not expect the findings to have any immediate effect on prescribing the medication. “*You have to ask the question, 'What's the alternative for people who are depressed and in pain?'*”³³

Nierenberg’s response was reminiscent of that of the chairwoman of the FDA advisory panel which licensed the use of the vagus nerve stimulator³⁴ as a treatment for depression despite evidence both of its lack of efficacy and of its propensity to cause harm on the basis that “... *anything that gives these people hope is potentially worthwhile.*”³⁵ A dissenting member of the panel, considered this argument to be specious:

Pancreatic cancer is a hopeless condition ... with a much higher death rate than chronic depression ... and we have as much evidence that this works for pancreatic cancer as it does for depression. Why not use it for that? ... This almost has a feel of 18th-century psychiatry ...”³⁶

The preceding discussion enables the following conclusions to be drawn:

1. Subsequent analyses of earlier research into the efficacy and safety of antidepressants which resulted in the uncovering of serious methodological flaws, in addition to disclosures concerning the influence of pharmaceutical industry on the publication of trial data, undermines – in the absence of compelling evidence

³⁰ Cipriani (2009), p.753: “... *we did not investigate important outcomes, such as side-effects, toxic effects, discontinuation symptoms, and social functioning.*”

³¹ In a response to a Parliamentary Question set down by the MP Paul Burstow, in February 2006. [online], available: <http://paulburstow.org.uk/news/624.html?PHPSESSID=801ceb21> [accessed: 27 November 2006].

³² Carey, B. (2006). ‘Antidepressants increase suicide risk in young adults, study finds.’ *The New York Times*. 6 December.

³³ *Ibid.*

³⁴ See discussion in Appendix J.

³⁵ Carey, B. (2005) ‘F.D.A. Considers Implant Device for Depression.’ *The New York Times*. 21 May.

³⁶ *Ibid.*

to the contrary – the claims of published research on antidepressants to being evidence-based and to being either efficacious or safe.

2. Some treatments for depression, despite lack of evidence as to their efficacy and despite concerns as to their safety, are administered on such spurious grounds as that “they give these people hope.”

3. In that antidepressants are the most widely used psychiatric medication, doubts as to the efficacy or safety of such medications should by virtue of the ‘Precautionary Principle’ and in the absence of compelling evidence to the contrary, be regarded as being applicable to other pharmaceutical psychiatric treatments and, in particular, to those administered coercively.

Appendix L: Problematic aspects of antipsychotic research

Note: As mentioned at the commencement of Chapter 5, the discussion of psychiatric treatments in this Appendix is not intended to provide a comprehensive, objective and balanced overview of research into antipsychotics. The goal is much more circumscribed: it is – by examining the published work of academic commentators and researchers in this area – to establish a *prima facie* case that clinical psychiatric practice in the use of antipsychotics, often lacks (and, on occasion, conflicts with) a robust evidence-base.

The goal of this appendix is to answer the following questions:

- (i) Does robust evidence for the efficacy and safety of antipsychotics exist?
- (ii) Do clinical psychiatrists manifest a sensitivity to the degree of harm sometimes occasioned by antipsychotics?
- (iii) Do clinical psychiatrists show a responsiveness to changing evidence on the efficacy and safety of antipsychotics?

The distorting influence of the pharmaceutical industry on psychiatric research has been discussed in Appendix J ; consequently independently funded research into psychiatric pharmaceutical treatments attains a heightened importance; the CATIE Study (2005) and the CUtLASS 1 Study (2006) (*infra*) are examples of such independently funded studies.

Adopting the methodology used in discussing antidepressants (Appendix K), this appendix is in the nature of a decade-long ‘timeline’ showing how radical was the change in attitudes wrought by the advent of independently funded research; it is structured as follows:

- Some preliminary matters [Subsection L-1];
- Brief outline of the development of antipsychotics [Subsection L-2];
- Some research findings: 1998-2005 [Subsection L-3];
- The CATIE Study (2005) [Subsection L-4];
- A note on minimal drug treatment [Subsection L-5];
- The CUtLASS 1 Study (2006) [Subsection L-6];
- Interim conclusions [Subsection L-7];
- Some research findings from 2007 [Subsection L-8];
- Some research findings from 2008 [Subsection L-9];
- Antipsychotic use in the treatment of children [Subsection L-10];
- Some research findings from 2009 [Subsection L-11];
- Some examples of industry manipulation of test results [Subsection L-12];
- Conclusions [Subsection L-13].

L-1: Some preliminary matters

The Oxford dictionary considers the terms ‘*neuroleptic*’, ‘*major tranquilliser*’ and ‘*antipsychotic*’ to be synonyms as does Webster’s dictionary which also gives the speciality (health) definition of ‘*neuroleptic*’ as:

A term coined to refer to the effects on cognition and behaviour of antipsychotic drugs, which produce a state of apathy, lack of initiative, and limited range of emotion and in psychotic patients cause a reduction in confusion and agitation and normalization of psychomotor activity.¹

Writing in the *Lancet*, Yawar (2009) sketches the history of these drugs:

In the 1950s, the chemical lobotomy, or “*hibernation therapy*” was introduced. Patients were given a drug that rendered them immobile and semiconscious for days, on the assumption that they would emerge improved. The drug was called a “*neuroleptic*”, or brain restrainer. Its name? Chlorpromazine. Since marketed as an antipsychotic, it is used, at lower doses, today.

Yawar (2009) also discusses some of the side effects of neuroleptics:

Antipsychotics are, at times, cruel drugs. Some cause shaking, salivation, restlessness, infertility, stiffness, agitation, and frail bones; others cause obesity, somnolence, and increase the risk of heart attack, diabetes, and stroke.

The side effects of one of the older antipsychotics *Haldol* (haloperidol) were described by Leonid Plyushch, a Soviet mathematician and dissident:

I was prescribed haloperidol in small doses. I became drowsy and apathetic. It became difficult to read books.
... I was horrified to see how I deteriorated intellectually, morally and emotionally from day to day. My interest in political problems quickly disappeared, then my interest in scientific problems, and then my interest in my wife and children. ... My speech became jerky, abrupt. My memory deteriorated sharply.²

Though *Haldol* is an older drug (a ‘typical’ antipsychotic) it is still in use both as an antipsychotic and as a ‘*chemical cosh*’.³

¹ Online available at: <http://www.websters-online-dictionary.org/ne/neuroleptic.html> [accessed: 7 March 2009].

² *The New York Times* (1976). ‘Excerpts from statement by dissident on his detention in Soviet mental hospital’. *The New York Times*, 4 February.

See also Bloch & Reddaway (1984). In discussing Plyushch’s case the authors attempt (p. 27-8) to distinguish the use of *Haldol* by western psychiatrists [“*conscientious psychiatrist’s caution ... scrupulous attention to .. dosage ...*”] from that by Soviet psychiatrists [“*... indiscriminate use of these drugs*”]. It is of note that Plyushch’s statement contradicts these assertions and makes reference to being given “*small doses*” of haloperidol. (*Supra*)

³ The term ‘*chemical cosh*’ refers to the use of medications (especially antipsychotics) to subdue individuals where the primary purpose is not to advance the interests of the individual subject, but for the convenience of others; see, for example: Ballard (2005) which is entitled: “*Drugs used to relieve behavioral symptoms in people with dementia or an unacceptable chemical cosh?*”.

See also reports of the use of *Haldol* by the US immigration service:

Senate testimony last month revealed that 56 deportees were given psychotropic drugs ... between Oct. 1, 2006, and April 30, 2007. Thirty-three of them had no history of psychological problems, but were given the medicine because of “*combative behavior*,” ... Soeoth’s medical records show he received an injection of *Haldol* and Cogentin, a medicine given with the anti-psychotic drug to

Plyushch's description of the effects of antipsychotics is not unusual: John Manweiler⁴ described the effects of such medication (administered over a period of ten years) as making him feel like a "zombie";⁵ Arnold Juklerød⁶ described his first injection of neuroleptic medication thus:

... a paralysis entered my left side ... [then] came a fear and restlessness completely new to me. ... The paralysis went ... upwards and took my mouth and pulled it up in an awkward position. I couldn't speak. I could hardly talk. I was terrified and frightened.⁷

The harms occasioned by the use of psychiatric medications can be divided into two broad categories:

- those physical harms such as diabetes or tardive dyskinesia,⁸
- those harms which trespass deeply onto the psyche of an individual *e.g.* the harm done to Plyushch which has been described as being: "*a threat to 'the precious inner life of man'.*"⁹

The harms caused by antipsychotics are of both types.

Harms of the first category will be discussed in this appendix.

Harms of the second type may occur with all psychoactive medications but in the case of antipsychotics – especially if they have been administered coercively – such harms may be of a level of invasiveness and intensity such that they dominate all other harms; they will be discussed in Chapter 7 where it will be argued that they constitute harms which may diminish or destroy the personhood of a subject.

*L–2: Brief outline of the development of antipsychotics*¹⁰

Chlorpromazine (*supra*) came into clinical use as an antipsychotic in 1952 but within two years the severity of the side effects (EPS)¹¹ became apparent. Although

reduce the facial spasms it can cause, said his attorney, Ahilan Arulanantham, of the American Civil Liberties Union. "*He has no history of violence of any kind, no disciplinary problems at all. He didn't resist in any way, whatsoever, ...*"

[Associated Press (2007). 'American Civil Liberties Union seeks to prevent forcible drugging of deportees.' *International Herald Tribune*. 10 October].

⁴ See Appendix H.

⁵ Browne (2005a).

⁶ See Appendix G.

⁷ Sandøy (1997).

⁸ US National Institute of Neurological Disorders and Stroke:

Tardive dyskinesia is a neurological syndrome caused by the long-term use of neuroleptic drugs.

... [it] is characterized by repetitive, involuntary, purposeless movements. Features of the disorder may include grimacing, tongue protrusion, lip smacking, puckering and pursing, ...

[online], available: <http://www.ninds.nih.gov/disorders/tardive/tardive.htm> [accessed: 7 March 2009].

⁹ Campbell (1976).

¹⁰ The information in this subsection is drawn from Shen (1999).

chlorpromazine remained the most prescribed antipsychotic in the 1960s and 70s, a number of similar drugs (such as haloperidol) with different chemical and side-effect profiles, were introduced. The presence of EPS was originally regarded as an indicator of the efficacy of the antipsychotic medication but in 1971 a drug, Clozapine, which appeared to cause minimal EPS, was believed to be effective. Clozapine was introduced into the US market in 1990:

... and rapidly destroyed the general conviction that the efficacy and EPS profile were linked, and led to an emerging concept of "*atypical*" antipsychotic drugs. Although no precise definition of this concept has ever been established, a drug with the property of "*atypicality*" shows a clinical profile with a low propensity to induce EPS ...¹²

Clozapine's success quickly led to the development of other atypical antipsychotic drugs and by 1999 five others had been released onto the US market.

In the late 1990s, the possibility that the adverse effects of antipsychotics might be so serious as to cause death was known; a Dublin coroner's inquest, for example, was told that these drugs had been the cause of death and that: "... *there had been an increase in the number of 'sudden unexplained deaths' in previously healthy patients taking normal dosages of antipsychotic drugs ...*"¹³

In the O'Donnell case [see *supra* Chapter 4], a year after having been convicted Brendan O'Donnell died from the side effects of an antipsychotic medication.¹⁴

L-3: Research findings on antipsychotics: 1998-2005

Thornley & Adams (1998) – noting that: "*Drug treatments are the bulwark of treatment of schizophrenia*"¹⁵ – sought to evaluate the quality of studies supporting such treatments. It was a particularly comprehensive study in that it examined 3181

¹¹ Acute Extrapramidal Symptoms (EPS) including parkinsonism, dystonias, and akathisia and tardive dyskinesia.

¹² Shen (1999), p.410.

¹³ Haughey, N. (1997). 'Woman died after reaction to drug.' *The Irish Times*. 11 November.

¹⁴ Haughey (1997):

Dr. Smith said O'Donnell's dosage of the anti-psychotic drug Thioridazine was "*definitely within the known and accepted safety range*". He had received the same drug six months before without any recorded side-effects.

Dr. Harbison said O'Donnell died of heart failure caused by the fatal intoxication of Thioridazine. The level of the drug in his blood during the post-mortem was just above the therapeutic range. Thioridazine had been found previously to have caused sudden unexplained deaths at levels below those detected in O'Donnell's blood. There was an element of "*idiosyncrasy*" in the reaction of people to this type of drug.

Haughey, N. (1997) 'O'Donnell died of cardiac failure linked with drug, inquest jury says'. *The Irish Times*, 27 November.

¹⁵ *Op. cit.*, p.1183.

publications (c. 2500 trials); drug trials (involving 437 different drugs) predominated¹⁶ of which 1187 involved antipsychotics.¹⁷

The study concluded that:

The quality of reporting in this large sample of trials was poor ... 1% (20) of the 2000 trials achieved a maximum quality score of 5. Just under two thirds (1280) scored 2 or less, ... We found little evidence that the quality of trial reporting improved with time. ... As low quality scores are associated with an increased estimate of benefit, schizophrenia trials may well have consistently overestimated the effects of experimental interventions.¹⁸

The study also noted that the drug trials commonly used haloperidol as the control drug which has “*obvious side effects that render successful blinding difficult, if not impossible.*”¹⁹

The distortions caused by the use of haloperidol as the control, was confirmed by Geddes (2000a) which was a meta-analysis of trials which compared atypical antipsychotics with conventional antipsychotics. Geddes (2000a) found that:

The dose of haloperidol significantly affected outcome in the 23 trials in which it was used. ... The observed advantage in favour of the atypical drug disappeared as the dose of haloperidol decreased. ... suggesting that many of the perceived benefits of atypical antipsychotics are really due to excessive doses of the comparator drug used in the trial.²⁰

Geddes (2000a) noted that the trials were of limited clinical value by virtue of, *inter alia*, their short duration²¹ and recommended the use of conventional antipsychotics over atypical antipsychotics as a medication of first choice.²² The data on adverse effects of antipsychotics was so limited that it was not included in the report.²³

Commenting on Geddes (2000a), an editorial²⁴ in *The Lancet* began by noting that:

An infectious optimism has infused the field of schizophrenia with the availability of the new "atypical" antipsychotics. ... prescription data suggest that atypical antipsychotics account for nearly three out of four new prescriptions for antipsychotics in North America. So, how can we reconcile this large shift in

¹⁶ Thornley & Adams (1998), p.1183: “*Drug treatments are the bulwark of treatment of schizophrenia, so it is not surprising that drug trials dominate the sample.*”

¹⁷ *Ibid.*, p.1182.

¹⁸ *Ibid.*

¹⁹ *Ibid.*, p.1183 and continues:

... In addition, because haloperidol is also a potent cause of adverse effects, most drugs to which it is compared will have favourable side effect profiles. Therefore, so long as the new experimental drug has moderate antipsychotic properties, favourable outcomes can be expected.

²⁰ *Op. cit.*, pp.1373-4.

²¹ *Ibid.*, p.1375.

²² *Ibid.*

²³ *Ibid.*, p.1372: “*There were few data on quality of life, specific side effects, or cost effectiveness, and we have therefore not included these outcomes in this report.*”; see also (p.1375):

With the exception of extrapyramidal side effects, there is little consistent reporting of adverse events. There are few data on quality of life or clinically relevant functional outcomes and few reliable data on the cost effectiveness of atypical antipsychotics - none in the United Kingdom.

²⁴ Kapur & Remington (2000).

prescribing practices ... with the sobering evidence provided by Geddes *et al*? Is this shift largely a victory of clinical hope and marketing hype over hard evidence, ...?

The editorial commented that whilst the atypical antipsychotics might have new side effects such as diabetes, the “*gain on extrapyramidal effects is unequivocal*”²⁵ – a considerably more robust conclusion than that drawn by Geddes (2000a).²⁶

The *British Medical Journal* published a number of responses²⁷ to Geddes (2000a) many of which took issue with the fact that Geddes (2000a) felt enabled to draw such firm conclusions from what was admitted to be poor quality research; others were concerned with the intensity of EPS [“*profoundly traumatic to be rendered rigid, trembling, unable to rest, or obese by drug treatment*”] and with their underreporting. In reply, Geddes reiterated the view that “*Unfortunately, the benefits on extrapyramidal side effects achieved by atypical antipsychotics are relatively modest.*”

The seriousness of some of the side effects associated with atypical antipsychotics had begun to emerge in the late 1990s; Hickey (1999) reported on a case of ‘*Neuroleptic Malignant Syndrome*’ (NMS)²⁸ which the authors believe, had been exacerbated by the use of an atypical antipsychotic and which resolved within a day of the antipsychotics being discontinued.

Wieden & Miller (2001) discussed the rating scales used to assess the adverse effects of antipsychotics and noted that: “*Most research on the assessment of antipsychotic side effects has focused on EPS, ... Few scales assess for non-EPS side effects.*”²⁹ and that scales “*emphasize objective severity at the expense of subjective distress.*”³⁰ They urged caution in relation to assessing the severity of non–EPS side effects and noted that:

... the EPS caused by conventional antipsychotics were initially thought to be minor and that it took many years to fully understand the terrible burden caused by EPS.³¹

They cited research by one of the authors which found “*no significant correlation between subjective distress ratings and concurrent objective findings on the ... [EPS Rating Scale].*”³² The implication of such research is that assessments of adverse effects of antipsychotics were limited in scope and that even within their restricted

²⁵ *Ibid.*, p.1360.

²⁶ Geddes (2000a), p.1374.

²⁷ BMJ (2001).

²⁸ Hickey (1999): “*Neuroleptic malignant syndrome (NMS) is a serious adverse reaction to neuroleptic drugs. It is characterized by muscle rigidity and elevated temperature ...*”

²⁹ *Op. cit.*, p.41.

³⁰ *Ibid.*

³¹ *Ibid.*, p.46.

³² *Ibid.*, p.43.

ambit, they were unreliable measures of the distress as experienced by the user of the antipsychotics. Stalman (2002) gives an indication of the severity of EPS:

The extrapyramidal symptom of akathisia (internal restlessness) is the most difficult for patients to tolerate. Akathisia causes patients to stop their medication and can clinically mimic psychosis.³³

An editorial in the *British Medical Journal* addressed some of the findings on non-EPS side effects of antipsychotics and, in particular, the question of whether they could be a cause of cardiac deaths:

... whether cardiac deaths are related to the illness itself or to the drugs used to treat it has remained unclear. Data from a very large American cohort of almost 100,000 outpatients with schizophrenia who were treated with antipsychotics were published recently and begin to suggest an answer: the drugs play a major part,
...³⁴

Mortimer (2005) – having studied the prescribing of antipsychotics in secondary care and found it “*unsatisfactory*” – examined antipsychotics prescribing in primary care and concluded:

... most is unsatisfactory. ... Half the regimes failed one or more audit criteria, leaving diagnosis aside. ... [and] adds to concerns regarding high levels of off-licence use of potentially harmful medication.
... community pharmacists reported insurmountable difficulty in establishing the diagnosis of patients prescribed antipsychotic drugs by their GPs even when case notes were scrutinized and personal enquiries made of the GPs.

They concluded:

Our patients' experience of worsening of symptoms and antipsychotic withdrawal syndromes is of particular concern. ... This excessive reliance on pharmacotherapy may bring with it irrational combinations of drugs³⁵ in inadequate doses for long periods: clearly contrary to the principles of rational evidence-based therapy.

Concerned about the lack of authoritative data on the safety and efficacy of atypical antipsychotics and the spiralling cost³⁶ and popularity of such drugs, the US National Institute of Mental Health (NIMH) published, in 2005, the results of a study [Lieberman (2005) – known as the CATIE³⁷ study] comparing the safety and efficacy of all existing

³³ [Emphasis added]; thus hindering the uncovering of possible misdiagnosis.

³⁴ Herxheimer & Healy (2002), p.1253.

³⁵ Mortimer (2005):

For instance another primary care audit of 170 patients prescribed atypical antipsychotics drugs found nearly all were subject to psychotropic polypharmacy, over a third had no licensed indication.

³⁶ Carey (2005): “*The new drugs account for \$10 billion in annual sales and 90 percent of the national market for antipsychotics;*” Carey also reported that a months supply of the conventional antipsychotic used in the study cost \$60 whereas the atypical antipsychotics cost between \$250 - \$520.

Carey, B. (2005). ‘Little Difference Found in Schizophrenia Drugs.’ *The New York Times*. 20 September.

³⁷ Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE).

atypical antipsychotics with a conventional antipsychotic.³⁸ This study was regarded as a landmark study in that it was the most comprehensive comparative study into antipsychotics ever conducted and which, furthermore, had been funded by the US government independently of pharmaceutical industry finance.³⁹

L-4: The CATIE Study (2005) [Lieberman (2005)]

Because of the difficulty in specifying criteria for judging a treatment to be ‘successful’, the study adopted as its primary outcome measure ‘duration to discontinuation of treatment for any cause’; hence the longer the subject continued on the treatment the more successful it was judged.⁴⁰ The main conclusion was that: “*The majority of patients in each group discontinued their assigned treatment owing to inefficacy or intolerable side effects or for other reasons.*”⁴¹

Not only did the study find that the side effects of antipsychotics were sometimes so severe as to be “*intolerable*”⁴² but it also found that, in relation to EPS, there were no significant differences between the atypical antipsychotics and the conventional antipsychotic.⁴³ Their final conclusion was that though one of the atypical antipsychotics (Olanzapine) was moderately superior to the other drugs in terms of the rates of discontinuation and rate of hospitalisation “*for an exacerbation of schizophrenia*”,⁴⁴ it had more severe side effects; the results for the other atypical antipsychotics were similar to the conventional antipsychotic in most respects.⁴⁵

An editorial⁴⁶ accompanying the study noted that: “*The results could be viewed as discouraging. No drug provided the majority of patients a treatment that lasted the full 18 months of the study.*”⁴⁷ and that whilst two atypical antipsychotics did appear to be more effective :

³⁸ Lieberman (2005), p.1215: “*Although haloperidol is the first-generation agent most commonly used for comparison, we chose to use perphenazine because of its lower potency and moderate side-effect profile.*”

³⁹ Vedantam, S. (2005b). ‘New Antipsychotic Drugs Criticized; Federal Study Finds No Benefit Over Older, Cheaper Drug.’ *The Washington Post*. 20 October; also:

“*The study has vital public health implications,*” said Thomas Insel, director of the National Institute of Mental Health, which funded the study. “*It is the largest, longest and most comprehensive, independent trial ever done to examine existing therapies for this disease.*”

⁴⁰ *Op. cit.*, p.1211.

⁴¹ *Ibid.*, p.1209.

⁴² *Ibid.*, p.1218: “*The times to discontinuation because of intolerable side effects were similar among the groups ...*”

⁴³ *Ibid.*:

In contrast to previous studies, the proportion of patients with extrapyramidal symptoms did not differ significantly among those who received first-generation and second-generation drugs in our study.

⁴⁴ *Ibid.*

⁴⁵ *Ibid.*, p.1209; p.1218.

⁴⁶ Freedman (2005a).

⁴⁷ *Ibid.*, p.1287.

... both drugs induce a significantly greater number of serious side effects. Even the most feared side effect of first-generation drugs, tardive dyskinesia, seems less troubling than potentially fatal metabolic problems.⁴⁸

Interviewed subsequently, one of the authors of the study commented: “*Many psychiatrists, in fact, were so certain the new drugs were better that they questioned the need to pit the new medications against an older drug*”⁴⁹

The lead author stated that:

Probably the biggest surprise of all was that the older medication produced about as good an effect as the newer medications, three of them anyway, and did not produce neurological side effects at greater rates than any of the other drugs, ...⁵⁰

The categorisation of the side effects of antipsychotics as being “*intolerable*” raises profound ethical questions in relation to the coercive administration of such drugs for extended periods of years to patients such as Manweiler or Juklerød (*supra*) who do not have the liberty to “*vote with their feet*”. The seriousness of the side effects of antipsychotics in addition to their ‘intolerability’ raises the question as to whether a non- or minimal drug treatment for schizophrenia might not be preferable.

L-5: A note on non- or minimal drug treatment for schizophrenia

Davis (2006) which was an editorial in the *New England Journal of Medicine*, was adamant on the need for the lifetime use of drugs in the treatment of schizophrenia; it stated, *inter alia*, that:

- (i) Schizophrenia is a serious chronic illness that requires lifelong medication.
- (ii) We have known for 30 years that a delay in initiating treatment with antipsychotic medication may increase the need for hospitalization over the subsequent five years.
- (iii) ... medication is typically needed for the rest of the patient's life. Patients who stop taking antipsychotic medications have a relapse rate of about 10 percent per month, until eventually almost all patients have a relapse.⁵¹

Of these three statements, authority is cited only for the second and in that case both of the studies cited⁵² were *circa* 30 years old and had been primarily concerned with a comparison between drug therapy and psychotherapy. The author of the second study

⁴⁸ *Ibid.*

⁴⁹ See Vedantam, S. (2005). ‘Psychiatric Drugs’ Use Drops for Children.’ *The Washington Post*. 8 October.

⁵⁰ See Carey (2005) (*supra*).

⁵¹ *Op. cit.*, p.520.

⁵² Davis (1978) and May (1976); the abstract of the latter states:

Patients who had been originally treated in hospital with psychotherapy alone stayed longer in hospital over the follow-up period than those who had received electroconvulsive therapy (ECT), drug alone, or drug plus psychotherapy. ...

summarised his findings in a later paper⁵³ which provide a less than adequate foundation for the unequivocal interpretation placed on them some thirty years later.

In view of the CATIE findings which showed that a previous near unanimity amongst the psychiatric profession on the superior efficacy and safety of atypical antipsychotics, was ill founded, the near unanimity on the necessity of drug treatment loses some of its authority.

Some months after the publication of Davis (2006), *The New York Times* reported⁵⁴ on responses to a then recently published study [Bola (2006a)]⁵⁵ which sought to directly examine the possibility of drug free treatment for schizophrenia and which “*exposes deep divisions in the field that are rarely discussed in public*”:

... some doctors suspect that the wholesale push to early drug treatment has gone overboard and may be harming patients ... Other experts warned that the new report's conclusions were dangerous, and represented only one interpretation of the evidence.⁵⁶

Lieberman – lead author of the CATIE study (*supra*) – was reported as stating:

I am usually a pretty moderate person, but on this I am 110 percent emphatic: If the diagnosis is clear, not treating with medication is a huge mistake that risks the person's best chance at recovery. It's just flat-out nuts.⁵⁷

Bola (2006a) – who had found that previous reviews concluding that drugs provided significant benefits included many studies that did not have a comparison group of people who were not on medication – reviewed six long-term studies involving 623 people who had symptoms of psychosis; in the studies, roughly half of the patients were promptly treated with antipsychotic drugs while the other half went without the medication for periods ranging from three weeks to more than six months. Two studies found that after a year or more, the patients on a full course of medication performed better on measures of social interaction, work success and the risk of rehospitalization

⁵³ May (1981) the abstract of which states:

Two hundred twenty-eight first-admission schizophrenic patients were randomly assigned to the following five treatments: psychotherapy alone, drug alone, ... The drug alone and ECT groups tended to have the best outcome and the psychotherapy alone group the worst. The positive effect from prior drug treatment began to dissipate after three years postadmission. For the in-hospital treatment successes, the advantage from drug treatment and the disadvantage from psychotherapy were less apparent. Overall, the follow-up outcome is far from reassuring, ...

⁵⁴ Carey, B. (2006a). ‘Revisiting Schizophrenia: Are Drugs Always Needed?’ *The New York Times*. 21 March.

⁵⁵ The study found that [Carey (2006a)]:

... when some people first develop psychosis they can function without medication — or with far less than is typically prescribed — as well as they can with the drugs. And the long-term advantage of treating first psychotic episodes with antipsychotics, the report found, was not clear.

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*

than those who were initially drug-free, whereas the other four studies found the opposite. The most important conclusion, however, related to the lack of research:

The most striking observation in this review is the dearth of good-quality evidence that addresses the long-term effects of initial treatment with antipsychotic medication compared with short-term medication postponement in early episode schizophrenia research.⁵⁸

Bola (2006b) discussed how the *Declaration of Helsinki*⁵⁹ had been interpreted to imply a categorical prohibition against research into the medication-free treatment of schizophrenia; he advocated that the prohibition be reconsidered; it also discussed how programmes in Finland and Sweden have helped subjects manage psychotic symptoms with either no, or minimal, use of medication. Due to methodological difficulties, the results of such programmes could not be incorporated into his results, nonetheless the results are worthy of note:

... researchers in Finland found that intensive family therapy helped more than 40% of patients with early symptoms of psychosis recover significantly without antipsychotics — and they have remained off the drugs, for more than two years. ... Another program, in Sweden, also has found that many people do well when treated with low doses of antipsychotic medications, or none at all, after their first psychotic break.⁶⁰

Indirect support for the non or minimal use of antipsychotics in the treatment of schizophrenia may also be found from studies which have found that the course and outcome of schizophrenia is better in so-called ‘third world’ countries – where the use of antipsychotics is less prevalent – than in ‘developed’ countries.⁶¹

Kuipers (2007) also offers limited support for the use of psychological therapies in the treatment of schizophrenia.⁶²

*L-6: The CUtLASS 1 Study*⁶³ [Jones (2006)]

The CUtLASS 1 study was funded by the UK National Health Service with no financial support from the pharmaceutical industry; it sought to test the hypothesis that the use of

⁵⁸ Bola (2006a), p.292.

⁵⁹ World Medical Association (2008).

⁶⁰ Carey (2006a).

⁶¹ See Cohen (2008), p.229:

That schizophrenia has a better course and outcome in countries of the developing world has become an axiom in international psychiatry. This belief emerges from a long history of cross-national research, with the most often cited evidence coming from 3 studies by World Health Organization (WHO) ... These studies have been cited as “*arguably the greatest achievements in psychiatric epidemiology,*” and their results as constituting “*the single most important*” finding in crosscultural psychiatry.

⁶² Kuipers (2007) begins: “*The present state of research provides sound evidence for the efficacy of psychological therapy in the treatment of schizophrenia.*”

⁶³ Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS 1).

second generation atypical antipsychotic drugs [‘SGAs’] in the treatment of schizophrenia, would lead to better quality of life⁶⁴ when compared with the older and cheaper first-generation drugs [‘FGAs’]. Despite the authors initial belief⁶⁵ that SGAs were superior,⁶⁶ their conclusion was a clear refutation of the hypothesis⁶⁷ with indications that the FGAs were actually the superior treatment.⁶⁸

The study also noted the continuing emergence of information concerning the extent and seriousness of adverse effects caused by the use of antipsychotics.⁶⁹

Two editorial commentaries accompanied the publication of Jones (2006). The first [Lieberman (2006)] was by the lead author of the CATIE study who noted that the results of the CUtLASS 1 were “*virtually identical*” to those obtained in the CATIE study and were:

... a conclusion that runs counter to the impressions of many clinicians and previous studies suggesting marked superiority of the SGAs and that belies the huge advantage in market share enjoyed by the SGAs in the United States and other parts of the world.⁷⁰

Lieberman (2006) then asks as to how “*the disconnect between the exuberant claims of the superiority of the SGAs and their disappointing performance*”⁷¹ could have arisen.

He offers two reasons: the short-term nature of industry funded trials and secondly:

... by an overly expectant community of clinicians and patients eager to believe in the power of new medications. At the same time, the aggressive marketing of these drugs may have contributed to this enhanced perception of their effectiveness in the absence of empirical evidence.⁷²

⁶⁴ In contrast to the CATIE study which used ‘time to discontinuation’ as its primary measure.

⁶⁵ Vedantam (2006):

The results are causing consternation. The researchers who conducted the trial were so certain they would find exactly the opposite that they went back to make sure the research data had not been recorded backward.

Vedantam, S. (2006). ‘In Antipsychotics, Newer Isn’t Better. Drug Find Shocks Researchers.’ *The Washington Post*. 3 October.

⁶⁶ A belief that was widespread in clinical psychiatry [see *infra*].

⁶⁷ Jones (2006), p.1085: “*We emphasize that we do not present a null result; the hypothesis that SGAs are superior was clearly rejected.*”

⁶⁸ *Ibid.*, p.1083: “*Statistical precision was limited, but the ITT analysis indicated that true effects may have been in the opposite direction for this primary outcome and for the main symptom assessments.*”

⁶⁹ *Ibid.*, p.1086:

These trials provide benchmark data on adverse effect burden, but this may represent an underestimate. Furthermore, a range of adverse effects of FGAs and SGAs is emerging. Serious weight gain, diabetes mellitus, and hyperlipidemia may all adversely affect quality of life.

[GR: Hyperlipidemia is the presence of raised levels of lipids in the blood and is a risk factor for cardiovascular disease]

⁷⁰ Lieberman (2006), p.1069.

⁷¹ *Ibid.*

⁷² *Ibid.*, p.1070.

He described the results as “sobering” especially as: “*there were no differences in the rates of extrapyramidal symptoms and TD between FGAs and SGAs in CUtLASS 1 and CATIE.*”⁷³

The second commentary [Rosenheck (2006)] noted that, in response to promises of reduced side effects:

... first-line use of SGAs has been advocated by guidelines from the *American Psychiatric Association*, the *United Kingdom's National Institute for Health and Clinical Excellence*, ... and the *Expert Consensus Guideline Series in the Treatment of Schizophrenia*, which observed as early as 1999 that SGAs were rendering conventional antipsychotics obsolete.⁷⁴

Rosenheck (2006), in noting the extreme discordance between the results of the CATIE and CUtLASS 1 studies and “*previously held certainties*”,⁷⁵ commented:

A basic assumption of clinical research is that the results of carefully conducted clinical trials of the same agents in the same illness should not be grossly inconsistent.⁷⁶

Rosenheck (2006) also noted that the risk of tardive dyskinesia with SGAs may have been underestimated.⁷⁷

The lead author of CUtLASS 1 was asked to explain how, despite the evidence, the prescribing of SGAs had become so prevalent:

“*Duped' is not right,*” he said. “*We were beguiled.*” ... “*Why were we so convinced?*” he asked, ... “*I think pharmaceutical companies did a great job in selling their products. ... It became almost a moral issue on whether you would prescribe these dirty old drugs,*” he added.⁷⁸

L-7: Some interim conclusions

The question arises as to whether the results of the CATIE and CUtLASS 1 changed the prescribing habits of clinical psychiatrists. Rosenheck (one of the authors of the CATIE study) stated: “... *the belief in the newer drugs was so ingrained that many psychiatrists insisted that the results could not be extrapolated to other old drugs,*...”⁷⁹ – a belief which appears to have been shared by the Director of Research at the American Psychiatric Association who was reported⁸⁰ to have cautioned against drawing broad

⁷³ *Ibid.*

⁷⁴ Rosenheck (2006), p.1074.

⁷⁵ *Ibid.*, p.1075.

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*, p.1076: “... *a meticulous replication of a 1985 study of TD at 1 community mental health center found no overall reduction in TD prevalence in 2003 in spite of widespread use of SGAs.*” [TD= Tardive Dyskinesia]

⁷⁸ Vedantam (2006) (*supra*).

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

conclusions from the CUtLASS 1 findings, stating that "*a thoughtful and prolonged process*" is needed before treatment guidelines are changed.

The author of the Cutlass 1 study has responded to such beliefs by stating that "*educated clinicians as well as their patients should begin to take into account the results of such trials.*"⁸¹ Urging the importance of trusting the data rather than clinical intuition and drawing on the analogy of his hobby of hill walking, he said:

Sometimes the compass tells you go straight in front of you, but you somehow know it is wrong and that north is behind you,... I have learned to follow the compass.⁸²

Heres (2006) sought to determine if pharmaceutical industry funding of research could account for the extreme divergence in the research findings; he found:

... a clear link between sponsorship and study outcome ... as 90.0% of the abstracts were rated as showing an overall superiority of the sponsor's drug. ... different comparisons of the same two antipsychotic drugs led to contradictory overall conclusions, depending on the sponsor of the study. ... reporting of adverse events seems to be selective ... Information on side effects that are very likely to occur ... may be lacking.⁸³

The underreporting of antipsychotic adverse effects was also discussed by Kane (2006) in an editorial in the *American Journal of Psychiatry*. The author had co-authored an earlier study which concluded that though tardive dyskinesia was still a risk with atypical antipsychotics it was substantially lower than with conventional antipsychotics. He sought to review these conclusions in light of the CATIE, and other findings. In the course of his editorial, Kane (2006) had noted that in relation to tardive dyskinesia:

... it took many years before its prevalence, incidence, and long-term course were well investigated. At first there was resistance and skepticism from many quarters as to the risk of this condition ... Some might argue that it was not until the threat of litigation became more and more a reality that clinical practice included adequate consideration of and monitoring for tardive dyskinesia.⁸⁴

This conclusion has an especial relevance to Ireland in that the provisions of the *Mental Health Act (2001)* effectively preclude litigation in relation to, *inter alia*, harm cause by the negligent prescribing of antipsychotics.

The extreme seriousness of the possible side effects of antipsychotics was highlighted by Lehtinen (2006) which was a 17 year follow up study of Finnish subjects who had

⁸¹ Jones (2007).

⁸² Vedantam (2006).

⁸³ Heres (2006), p.189.

⁸⁴ Kane (2006), p.1316.

been diagnosed with schizophrenia and treated with antipsychotics. It found that such subjects were 2.5 times more likely to die and that this risk was proportionately related to the amount of neuroleptic that had been prescribed. Lehtinen (2006) concluded that:

There is an urgent need to ascertain whether the high mortality in schizophrenia is attributable to the disorder itself or the antipsychotic medication.⁸⁵

The discordances between the results of independent and industry funded studies, the reluctance of clinical psychiatrists to change their beliefs in the face of new evidence, the underestimation of the harm caused by antipsychotics, are so great as to permit the drawing of some interim conclusions.⁸⁶

(i) *The incontrovertible conclusion to be drawn from the existence of grossly inconsistent results in relation to trials of first and second generation antipsychotics, is that many supposedly evidence-based studies supporting the psychiatric use of antipsychotics, are deeply flawed.*

(ii) *There is clear evidence of a reluctance amongst clinical psychiatrists to change their beliefs in relation to the appropriate prescribing of antipsychotics, in the face of authoritative, independently funded, studies such as CATIE and CUtLASS 1.*

(iii) *There are substantial grounds for holding that both the extent and the severity of harms associated with the use of both first and second generation antipsychotics, have been grossly underestimated both by researchers and by clinical psychiatrists.*

L-8: Some research findings from 2007

Marder (2007) which was an editorial in the *American Journal of Psychiatry* spoke⁸⁷ of mild forms of extrapyramidal symptoms which, though difficult to detect for trial raters or treating psychiatrists, “*can be tormenting if a person experiences it all of his or her waking hours.*”⁸⁸ He suggested that: “*It would not be surprising if the raters from CATIE were not sensitive to these mild manifestations.*”⁸⁹ – a comment which, in itself, indicates both the underreporting of the adverse effects of antipsychotics and the extreme discordance between raters’, and subjects’, perceptions of the seriousness of side effects.⁹⁰

Bick (2007) also revisited the CATIE study but from a different perspective – that of underlying, and possibly causative⁹¹ – physical illness:

⁸⁵ *Op. cit.*, p.122.

⁸⁶ These conclusions will be revisited at the end of this appendix.

⁸⁷ In discussing a CATIE follow-on trial which is not of interest in the present context.

⁸⁸ Marder (2007), p.376.

⁸⁹ *Ibid.*

⁹⁰ Which should also be viewed in the light of a similar discordance found in early reports of tardive dyskinesia [See *supra*].

⁹¹ See Chapter 4.

- The most stunning finding was that psychiatrists tend to ignore life-threatening, treatable medical conditions in patients presenting for treatment with schizophrenia. Of patients entering the study, 45% had untreated diabetes, 89% had untreated hyperlipidemias and 62% had untreated hypertension. ...
- [CATIE] did expose a woeful standard in the medical management of schizophrenia offered by psychiatrists.⁹²

L-9: Some research findings from 2008

Kahn (2008), which was industry funded, sought to compare the effectiveness of second-generation antipsychotic drugs with that of a low dose of haloperidol in first-episode schizophrenia. They found – in contrast to CATIE – that ‘*time to discontinuation*’⁹³ was greater for the second generation antipsychotics than for haloperidol,⁹⁴ but that:

... we cannot conclude that second-generation drugs are more efficacious than is haloperidol, since discontinuation rates are not necessarily consistent with symptomatic improvement.⁹⁵

Kahn (2008) noted that even in short term studies of less than 8 weeks: “... *fewer than 50–60% of patients continue to take their drugs before the study is complete.*”⁹⁶ – eloquent testimony to either the ineffectiveness of the drugs or the severity of their side effects or both.

A more telling result concerning the side effects of antipsychotics was mentioned in an interview with the psychiatrist Nancy Andreasen:⁹⁷

The big finding is that people with schizophrenia are losing brain tissue at a more rapid rate than healthy people of comparable age. Some are losing as much as 1 percent per year. That's an awful lot over an 18-year period. And then we're trying to figure out why. Another thing we've discovered is that the more drugs you've been given, the more brain tissue you lose.⁹⁸

⁹² Bick (2007), p.465.

⁹³ The criterion used by CATIE.

⁹⁴ Kahn (2008) suspected (p. 1095) that the distinctive side effects of haloperidol could have led to the ‘*breaking of the blind*’.

⁹⁵ *Ibid.*, p.1085.

⁹⁶ *Ibid.*

⁹⁷ Andreasen is also a neuroscientist and was one of the first to use neuroimaging techniques in the study of psychiatric disorders.

⁹⁸ Dreifus, C. (2008). ‘A Conversation With Nancy C. Andreasen: Using Imaging to Look at Changes in the Brain.’ *The New York Times*. 15 September.

Asked as to the implications of this finding she said:

- (i) That these drugs have to be used at the lowest possible dose, which often doesn't happen now. There's huge economic pressure to medicate patients very rapidly and to get them out of the hospital right away.
- (ii) We need to find other drugs that work on other systems and parts of the brain.
- (iii) Whatever medications we use need to be combined with more nonmedication-oriented treatments, like cognitive or social therapies.

This interview drew a critical response from some other psychiatrists: “*The fact that ‘the more drugs you've been given, the more brain tissue you lose’ may be explained by the fact that individuals with more*

The May 2008 issue of the journal *Psychiatric Services* focused on the CATIE results and the implications that should be drawn from them. A number of the contributors argued for a preservation of the *status quo ante*.⁹⁹ However, the issue's editorial – in acknowledging that “*We professionals share the human tendency to embrace fads*” – argued that the appropriate response to CATIE was:

... we must share the uncertainties with our patients. Informed consent helps to ensure that patients are aware of their options for treatment, including no treatment, and of how their preferences and individual characteristics might influence their quality of life. Increasing patients' participation in informed decision making empowers both patients and their clinicians and respects patients' autonomy.¹⁰⁰

Whilst the embracing of such uncertainties is to be welcomed, they are hardly compatible with the coercive use of such antipsychotics.

L-10: Antipsychotic use in the treatment of children and adolescents

Further articles examined the ever widening ‘consumer-base’ for antipsychotics. Domino & Swartz (2008), for example, found that the substantial increase in the use of antipsychotics did not occur amongst individuals diagnosed with schizophrenia but for other conditions such as bipolar disorder and a “*a high, constant rate of off-label use.*” Their conclusion was that: “*The rapid diffusion of second-generation antipsychotic medications was achieved by large increases in the rate of use in certain subpopulations, most notably youths.*” Because of the limited efficiency and the risks associated with antipsychotics, “*the dramatic increase in use warrants attention.*”¹⁰¹ The increase in the rate of antipsychotic prescribing for children and adolescents was also discussed in Kalverdijk (2008) who examined Dutch statistics and found that:

severe schizophrenia are given more drugs.” [Torrey, E. & Chase, C. (2008). ‘Letters: Schizophrenia's Toll’. *The New York Times*. 23 September.]

A later study by Andreasen *et al* [Ho (2011)] found that the progressive brain volume changes in those diagnosed with schizophrenia, that had been previously attributed to the disease, can, in part, be attributed to the use of antipsychotics. See also Goff (2011) who discusses how the brains of animals given antipsychotics for “*17 to 27 months lost roughly 10% of their total brain volume*”.

⁹⁹ Swartz (2008): “*Although the CATIE results are controversial, they are broadly consistent with most previous antipsychotic drug trials and meta-analyses.*”

Owens (2008) concludes that CATIE's achievement lay in “*... reinstating to physicians their key skill in expert, individualized prescribing.*”

Franks (2008) urges caution on use of CATIE as the cornerstone of new formulary policies.

¹⁰⁰ Sutton (2008).

¹⁰¹ Domino & Swartz (2008), p.507.

From 1997 to 2005, prevalence increased from 3.0 to 6.8 per thousand. Prevalence was highest among ten-year-olds to 14-year-olds (11 per thousand), especially among boys (17 per thousand).¹⁰²

A high and increasing level of antipsychotic prescribing for children and adolescents was also evident in the US where atypical antipsychotics prescriptions for children rose from 600 (per 100,000 doctor visits) in 1998 to 2,450 in 2004 with 80% of the prescriptions for conditions other than schizophrenia, 49% being for disruptive behaviour.¹⁰³ These levels of prescribing of atypical antipsychotics for children raised concerns about the increased risk of adverse effects. Two studies [Findling (2008), Sikich (2008)] in the *American Journal of Psychiatry* sought to address these concerns, which were also the focus of an editorial [Sikich (2008)].

Findling (2008) was a 6-week study of Aripiprazole¹⁰⁴ as a treatment for adolescent schizophrenia. Having commented that there was a “*paucity*” of other relevant studies,¹⁰⁵ it found that:

The most common adverse events associated with aripiprazole were extrapyramidal disorder, somnolence and tremor ... The rates of serious treatment-emergent adverse events were low for all groups ...¹⁰⁶

It concluded that: “*Aripiprazole ... was more efficacious in ameliorating the symptoms of schizophrenia than was placebo ... Although considerable improvement was also observed with placebo, ...*”¹⁰⁷ and recommended that longer-term trials were necessary to confirm the drugs efficacy and safety.¹⁰⁸

Sikich (2008) – which was a publicly funded study (TEOSS)¹⁰⁹ – was designed to compare the safety and efficacy of two atypical antipsychotics [olanzapine (*Zyprexa*) and risperidone] with a first generation antipsychotic [molindone] in the treatment of children and adolescents. The authors noted that atypical antipsychotics are considered the “*standard treatment*” even though their superiority over first generation antipsychotics had never been demonstrated.¹¹⁰ The belief in the superiority of atypical antipsychotics amongst clinical psychiatrists was so great as to raise “... *significant ethical concerns about utilizing any first-generation antipsychotic in comparison with*

¹⁰² Kalverdijk (2008), p.554.

¹⁰³ Carey, B. (2008). ‘Risks Found for Youths in New Antipsychotics.’ *The New York Times*. 15 September.

¹⁰⁴ An atypical antipsychotic licensed for the treatment of adult schizophrenia and bipolar disorder.

¹⁰⁵ Findling (2008) mention a 4-week study of 75 adolescents and an 8-week study of 107.

¹⁰⁶ *Ibid.*, p.1438.

¹⁰⁷ *Ibid.*, p.1439.

¹⁰⁸ *Ibid.*

¹⁰⁹ Treatment of Early-Onset Schizophrenia Spectrum Disorders (TEOSS).

¹¹⁰ Sikich (2008), p.1420.

second-generation antipsychotics."¹¹¹ and to preclude using a drug-free arm which the study authors had considered.¹¹²

In relation to efficacy the study concluded that:

... only small differences among treatments emerged, which was not what we predicted. We did not find any evidence of superiority of the two second-generation antipsychotics ... over the first-generation antipsychotic,¹¹³

However:

Across all three treatments, more than half the participants failed to achieve an adequate response after 8 weeks of therapy. The mean reductions in psychotic symptoms were modest, ... Furthermore, 10 participants (8%) required hospitalization during the acute trial, primarily as a result of increased psychotic symptoms."¹¹⁴

In relation to side effects:

Adverse effects led to premature treatment discontinuation in eight patients in the molindone group, six patients in the olanzapine group, and five patients in the risperidone group ... Frequent adverse events included sedation, irritability, and anxiety ... Youth treated with olanzapine gained an average of 6.1 kg.¹¹⁵ ... those associated with olanzapine and risperidone are likely to have persistent effects on long-term physical health.¹¹⁶

The increases in cholesterol levels and other metabolic disruptions in the olanzapine group were such that they may have become dangerous and prompted the safety review board to stop the olanzapine arm of the study before it had been completed.¹¹⁷

The final conclusions were that:

These findings have broad public health implications. In the long term, the metabolic side effects of olanzapine and risperidone may place many youth at risk for diabetes and cardiovascular problems. Second-generation antipsychotics are now widely used to treat nonpsychotic mood and behavioral disorders in youth. The balance between potential therapeutic benefits and risk of adverse events needs to be carefully considered in this age group.¹¹⁸

The editorial which accompanied the publication of both studies, noted the limited efficacy of all the antipsychotics that had been tested, particularly when contrasted with placebo treatment:

¹¹¹ *Ibid.*

¹¹² *Ibid.*, p.1427.

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*, p.1425.

¹¹⁵ *Ibid.*, p.1424.

¹¹⁶ *Ibid.*, p.1425.

¹¹⁷ Press release from *National Institute for Mental Health* [online], available: <http://www.nih.gov/news/health/sep2008/nimh-15.htm> [accessed: 20 March 2009].

¹¹⁸ Sikich (2008), p.1428–9.

For both studies, the target mean dose was reached within 2 weeks of study onset. All treatment arms (including placebo) demonstrated a 12%–16% decrease in symptoms over the first 2 weeks of treatment. By 6 weeks, the placebo arm had a symptom decrease of 22%, while the active treatment arms had decreases of 23%–30%.¹¹⁹

The widespread – and often off-label – use of atypical antipsychotics as shown by, for example, Kalverdijk (2008) (*supra*), in conjunction with extremely limited evidence as to their efficacy and the seriousness of the side effects is striking and provides little comfort for those who argue that clinical paediatric psychiatry is an evidence-based discipline. Furthermore, the ethical concerns raised by psychiatrists on the use of conventional antipsychotics in place of atypical antipsychotics was shown to be deeply misplaced in that it effected an interdict against seeking supporting evidence, yet when the evidence was obtained it showed that the use of atypical antipsychotics in adolescents was likely to cause “*persistent effects on long-term physical health*” (*supra*). This provides a cautionary tale against yielding to the similar concerns which have been raised against examining the evidence for non-drug treatment of schizophrenia.

Further evidence on the extent and severity of the adverse effects of the adult use of antipsychotics emerged in Douglas & Smeeth (2008) which sought to determine whether the adult use of antipsychotics increased the risk of stroke. The study had been based on the General Practice Research Database and thus had access to the records of over 6 million patients; this allowed the authors to conclude that the study was: “... *large and statistically powerful ... largely representative of the population of the UK and so the results are likely to be highly generalisable.*”

The study concluded that:

All antipsychotics are associated with an increased risk of stroke, and the risk might be higher in patients receiving atypical antipsychotics than those receiving typical antipsychotics. ... During the periods after treatment the rate ratio fell towards unity.

The increased risk of stroke was further analysed according as to whether dementia was present; the data is summarised in the following table:

¹¹⁹ Ross (2008), p.1371 [Emphasis added]

	<i>No Dementia Present</i>	<i>Dementia Present</i>
<i>Typical Antipsychotics</i>	140%	326%
<i>Atypical Antipsychotics</i>	190%	586%

Table L-1: Increased risk of stroke associated with antipsychotics use

Evidence that the use of atypical antipsychotics can nearly double the risk of stroke gives an added emphasis to the warnings of psychiatrists such as Moncrieff (2007) who berates her fellow psychiatrists for ignoring the evidence of the harm caused by antipsychotics thereby risking “*an epidemic of iatrogenic brain damage.*”¹²⁰ It gives an additional urgency to addressing Lehtinen’s (2006) concern (*supra*) that the high mortality in schizophrenia is attributable to the use of antipsychotics; some of these concerns were addressed by Ray (2009) which is discussed in the following subsection.

L-11: Some research findings from 2009

Ray (2009), which was an analysis of more than 250,000 Medicaid records, was the first study to rigorously document the risk of cardiac harm attributable to the adult use of atypical antipsychotics.¹²¹ The study concluded that:

Current users of typical antipsychotic drugs had an adjusted rate of sudden cardiac death that was twice that for nonusers ... A similar increased risk was seen for current users of atypical antipsychotic drugs, who had a rate of sudden cardiac death that was more than twice that for nonusers ... The risk of sudden cardiac death increased with an increasing dose ...¹²²

By using a parallel secondary analysis of those subjects who had not been diagnosed with schizophrenia they were able to answer the concern raised by Lehtinen (2006) (*supra*) – in so far as it related to deaths due to cardiac arrest – and to conclude that the increased risk was attributable to antipsychotic use rather than any underlying psychiatric condition.

An accompanying editorial¹²³ noted, without comment, that:

It is striking that it took so long to establish the elevated risk associated with atypical antipsychotic medications given that the first agent in this class ... entered the U.S. market in 1989.¹²⁴

Given the increased risk, it is important to judge it in context and to ask ‘*how common is sudden cardiac death among adults treated with antipsychotic medications?*’ Ray

¹²⁰ James, A. (2008). ‘Myth of the antipsychotic’. *The Guardian*. 2 March: “‘*It is as if the psychiatric community can not bear to acknowledge its own published findings,*’ she writes.”

¹²¹ Carey, B. & Rabin, R. (2009). ‘Study Finds Drug Risks With Newer Antipsychotics.’ *The New York Times*. 14 January.

¹²² Ray (2009), p.225.

¹²³ Schneeweiss & Avorn (2009).

¹²⁴ *Ibid.* and noted that three of the antipsychotics: “*Zyprexa, ... Risperdal, ... Seroquel, are among the 10 top-selling drugs worldwide, with a combined sales volume of \$14.5 billion in 2007.*”

(2009) estimated the prevalence at 2.9 events per 1000 patient-years. A commentary on this stated: “*The risk of death from the drugs is not high, on average about 3 percent in a person being treated at least 10 years.*”¹²⁵

Such a perspective must be viewed against an earlier editorial in the *New England Journal of Medicine*¹²⁶ which advocated a life time use of antipsychotics in the treatment of schizophrenia; within such a context and analysing the risk-profile of ten subjects diagnosed with schizophrenia and using antipsychotics for a period of 30 years, Ray (2009) implies that 1 will die from cardiac arrest. Seen in the context of a lifetime use of antipsychotics, the risk of death due to cardiac arrest cannot – at 10% – be described as being “*not high*”.

Leucht (2009) was a meta-analysis of 150 double-blind randomised controlled trials of antipsychotics. Its goal was to compare the effects of conventional antipsychotics and atypical antipsychotics in the treatment of patients with schizophrenia; it was funded by the National Institute of Mental Health. It differed from earlier studies such as Geddes (2000a) (*supra*) which analysed only one efficiency outcome; it differed from *CATIE* and *CULASS* in that they used comparator drugs that are less potent than haloperidol whereas according to Leucht (2009): “*A major limitation of our meta-analysis is that haloperidol was the comparator drug in most of the studies.*”¹²⁷

Leucht (2009) concluded that:

Four of these¹²⁸ drugs were better than first-generation antipsychotic drugs for overall efficacy, with small to medium effect sizes ... The other second-generation drugs were not more efficacious than the first-generation drugs, even for negative symptoms. ...

Only a few have been shown to induce fewer extrapyramidal side-effects than low-potency first-generation antipsychotic drugs.¹²⁹

The study noted that of the 150 studies, only 14 reported on the rate of relapse and 17 on the quality of life of medicated subjects and that “*In previous meta-analyses ... side-effects were not assessed thoroughly.*”¹³⁰ Their final conclusion was to the effect that because atypical antipsychotics differ in many of their properties:

... they do not form a homogeneous class and neither do first-generation antipsychotic drugs. Improper generalisation creates confusion and as a result the classification might be abandoned. ...

The second-generation drugs are expensive, and cost-effectiveness has not been

¹²⁵ Carey & Rabin (2009).

¹²⁶ Davis (2006) (*supra*).

¹²⁷ *Op. cit.*, p.40.

¹²⁸ *I.e.* atypical antipsychotics.

¹²⁹ *Op. cit.*, p.31.

¹³⁰ *Ibid.*

proven. Public institutions could save costs by funding studies to accurately define selected old compounds, because they were not rigorously studied at the time they were introduced.¹³¹

Tyrer & Kendall (2009) in an editorial accompanying Leucht (2009), comment that:

... what was seen as an advance 20 years ago ... is now, and only now, seen as a chimera that has passed spectacularly before our eyes before disappearing and leaving puzzlement and many questions in its wake. ...

The spurious invention of the atypicals can now be regarded as invention only, cleverly manipulated by the drug industry for marketing purposes and only now being exposed.¹³²

In an echo of the comment by the lead author of Jones (2006) (*supra*), they ask: “*But how is it that for nearly two decades we have ... ‘been beguiled’ into thinking they were superior?*”¹³³ A rhetorical question that eloquently reflects the woeful standard of evidence which had been used by clinical psychiatrists for over a decade, to justify their belief in the superiority of atypical antipsychotics.

L–12: Examples of industry manipulation of test results

Sketched below are three examples – Zyprexa [L–12(i)], Seroquel [L–12(ii)] and Neurontin¹³⁴ [L–12(iii)] – where either negative test data was withheld or where the pharmaceutical company engaged in illegal practices such as off-label marketing, which were uncovered in litigation undertaken in US courts.

There is a more complete discussion of such practices in Appendix J.

L–12(i): Zyprexa

Eli Lilly (the manufacturer of Zyprexa) had been found by the courts to have withheld data which had shown that the antipsychotic caused obesity and diabetes. Under threat of criminal proceedings the company had offered \$1 billion as payment of a fine in addition to \$1.2 billion already paid in settlement of civil actions. Eli Lilly sales material encouraged representatives to engage in off-label marketing and to promote Zyprexa as a “*safe, gentle psychotropic*” suitable for people with mild mental illness.¹³⁵

¹³¹ *Ibid.*, p.40.

¹³² *Op. cit.*, p.4. They also note some of the methods whereby this sleight of hand has been achieved (*e.g.* high doses of haloperidol as a comparator; selective publication).

¹³³ *Ibid.*

¹³⁴ Though Neurontin is not strictly an antipsychotic, it has been used as a treatment for tardive dyskinesia and is thus associated with the use of antipsychotics. [See Hardoy (2003)].

¹³⁵ Berenson, A. (2006). ‘Eli Lilly Said to Play Down Risk of Top Pill’. *The New York Times*. 17 December.

L-12(ii): Seroquel¹³⁶

AstraZeneca (the manufacturers of Seroquel) were sued in a class action comprising 9,200 patients who alleged that their diabetes was caused by their use of Seroquel. Details of a research study known as ‘Study 15’ emerged during proceedings; it had been completed in 1997 but never made public nor made known to clinicians though provided to the FDA.¹³⁷

The drug was approved by the FDA in 1997, was widely prescribed and “*has earned billions for ... AstraZeneca ... including nearly \$12 billion in the past three years.*”

Study 15 showed that the test subjects gained an average of 11 pounds a year – a result which precipitated an exchange of e-mails between company executives:

- [X] reported that across all patient groups and treatment regimens, regardless of how numbers were crunched, patients taking Seroquel gained weight: “*I’m not sure there is yet any type of competitive opportunity no matter how weak.*” ...
- [Y] praised AstraZeneca’s efforts to put a “*positive spin*” on “*this cursed study*” and said of Arvanitis: “*Lisa has done a great ‘smoke and mirrors’ job!*” “*Thus far, we have buried Trials 15, 31, 56 and are now considering COSTAR.*”

In 1999, two years after those exchanges, the company presented different data at an American Psychiatric Association conference, to the effect that Seroquel helped psychotic patients lose weight – a claim which was based on a company-sponsored study by a psychiatrist who had reviewed the records of 65 patients who had switched their medication to Seroquel.

L-12(iii): Neurontin¹³⁸

Neurontin had been approved by the FDA for a very narrow use in the controlling of seizures in epileptics but had been widely prescribed off-label.

Under a so-called ‘shadowing’ programme which came to light during a civil and criminal investigation of the drug’s manufactures (Pfizer):

- ... physicians, in exchange for money, have allowed pharmaceutical sales representatives into their examining rooms to meet with patients, review medical charts and recommend what medicines to prescribe.

Pfizer tracked whether doctors prescribed Neurontin, “*rewarding those who were considered high-volume prescribers by paying them as speakers and consultants*”

¹³⁶ The information below has been drawn from Vedantam (2009) except where otherwise stated. Vedantam, S. (2009). ‘A Silenced Drug Study Creates An Uproar.’ *The Washington Post*. 18 March.

¹³⁷ Though “*the agency has strenuously maintained that it does not have the authority to place such studies in the public domain.*”

¹³⁸ The information below has been drawn from Peterson (2002) except where otherwise stated. Peterson, M. (2002). ‘Suit Says Company Promoted Drug in Exam Rooms.’ *The New York Times*. 15 May.

In 2000, more than 78% of Neurontin prescriptions were written for off-label uses.

However, some psychiatrists had found that:

... some patients taking Neurontin for schizophrenia or bipolar disorder appeared to become more aggressive after starting on the drug. ... “*Neurontin is being used like water for disorders where there is not much evidence it is effective, ...*”

Pfizer pleaded guilty to criminal charges and was fined \$430 million;¹³⁹ it was also found to have manipulated test data, suppressed negative test results and fraudulently manipulated the drug’s supposed benefits.¹⁴⁰

L-13: Some conclusions concerning the safety and efficacy of antipsychotics

Having discussed the CATIE and CUtLASS 1 findings (*supra*) three interim conclusions were drawn [L-7 *supra*]. The goal of this final subsection is to see whether the studies published between 2006 and 2009 necessitate a revision of these interim conclusions.

The first interim conclusion was to the effect that the existence of grossly inconsistent results regarding the safety and efficacy of atypical antipsychotics implied that some earlier studies were deeply flawed. The statement by a *Lancet* editorial¹⁴¹ that the advent of the supposedly safer and more efficacious atypical antipsychotics: “... *is now, and only now, seen as a chimera that has passed spectacularly before our eyes ...*”, in addition to evidence of the manipulation of test results in published studies, adds further strength to that interim conclusion and allows it to be stated without reservation:

1. *The inference to be drawn from the existence of grossly inconsistent results in relation to trials of first and second generation antipsychotics, is that some supposedly evidence-based studies supporting the psychiatric use of antipsychotics, are deeply flawed.*

The second interim conclusion concerned the reluctance of clinical psychiatrists to change their beliefs concerning the safety and efficacy of atypical antipsychotics in the light of new and authoritative disconfirmatory evidence.

The continuously increasing use of atypical antipsychotics (including evidence of extreme levels¹⁴² of off-label use), especially in the treatment of children and young adults,¹⁴³ in the face of mounting evidence¹⁴⁴ as to risk of serious adverse effects such

¹³⁹ Harris, G. (2004). ‘Pfizer to Pay \$430 Million Over Promoting Drug to Doctors.’ *The New York Times*. 14 May.

¹⁴⁰ Saul, S. (2008). ‘Experts Conclude Pfizer Manipulated Studies.’ *The New York Times*. 8 October.

¹⁴¹ Tyrer & Kendall (2009) (*supra*).

¹⁴² See, for example, (*supra*) 78% of Neurontin prescriptions were for off-label use.

¹⁴³ As shown by, for example, Kalverdijk (2008) (*supra*).

¹⁴⁴ See, for example, Sikich (2008) (*supra*).

as EPS and diabetes and “*persistent effects on long-term physical health*” (*supra*), suggests that the beliefs of clinical psychiatrists in relation to the use of atypical antipsychotics is relatively immune from readily available disconfirming evidence. In that the reluctance to adjust robustly held views in the face of disconfirming evidence is one of the criteria used by psychiatrists in the definition of delusional behaviour,¹⁴⁵ this conclusion is disconcerting. In these circumstances, the second interim conclusion can only be strengthened:

2. There is a manifest reluctance amongst clinical psychiatrists to changing their beliefs in relation to the appropriate prescribing of antipsychotics, in the face of authoritative disconfirming evidence relating to the safety and efficacy of atypical antipsychotics.

The third interim conclusion was to the effect that both the extent and severity of harms associated with antipsychotics use had been underestimated.

Results published in the years between 2006 and 2009:

- as to the risk of diabetes and EPS,
- long term and extensive brain damage,¹⁴⁶
- the doubling of the risk of stroke,¹⁴⁷
- the limited duration of drug trials (6 -8 weeks) when compared to a possible lifetime use of such drugs,
- the lack of attention paid to possible adverse effects and to the subjective effect of such adverse effects,¹⁴⁸
- the reluctance of clinical psychiatry to acknowledge the seriousness of the adverse effects of antipsychotics as evidenced by its earlier attitude towards the emergent risk of tardive dyskinesia,¹⁴⁹

suggest not only a stronger conclusion in relation to the underestimation of harm, but also the conclusion that clinical psychiatry appears to be somewhat inured to the possibility of such harm.

Kane (2006) (*supra*) had suggested that it was the threat of litigation that forced clinical psychiatry to confront the risk of tardive dyskinesia. If this is correct, the effective absence of legal recourse under Irish Law in respect of harm occasioned by coercive treatment with antipsychotics, is in need of urgent redress.

¹⁴⁵ See Chapter 2 (*supra*).

¹⁴⁶ See Andreasen (*supra*).

¹⁴⁷ See Douglas & Smeeth (2008) (*supra*).

¹⁴⁸ See Leucht (2009) (*supra*) who noted that of the 150 studies examined, only 14 reported on the rate of relapse and 17 on the quality of life of medicated subjects and that “*In previous meta-analyses ... side-effects were not assessed thoroughly.*”

¹⁴⁹ Kane (2006) (*supra*).

3. There are substantial grounds for holding not only that the extent and the severity of harms associated with the use of antipsychotics have been grossly underestimated both by researchers and by clinical psychiatrists, but that even when the magnitude of such harms has been conclusively established, it has not informed the beliefs of psychiatrists as reflected in their prescribing habits. The implementation of an effective means for seeking legal redress for those harmed by coercive treatment with psychotropic medication, is a precondition for the minimising of iatrogenic harm consequent on psychiatric intervention.

Appendix M: Journal searches for rates of psychiatric misdiagnosis

In an attempt to locate estimates of the rates of psychiatric misdiagnosis, journal searches were undertaken; these searches were of two types:

- searches of journals which were not specific to psychiatry for occurrence of the phrase ‘*psychiatric misdiagnosis*’ anywhere in the text *i.e.* in the title, abstract or body of the journal article. [*Subsection M-1*]

Contrary to expectations these searches elicited so few results that a further search was undertaken for articles which contained both the terms ‘*psychiatric*’ and ‘*misdiagnosis*’ but not necessarily adjacent nor in the same context.¹

- searches of psychiatric journals for occurrences of the term ‘*misdiagnosis*’ firstly in the title or abstract, and secondly, anywhere in the text. [*Subsection M-2*]

Within these results, a further search was undertaken for ‘*compulsory admission*’ in an attempt to find estimates of the proportion of coercive psychiatric interventions that had been grounded in a misdiagnosis.

The conclusions drawn from these searches are discussed in Chapter 4, Section D.

*M-1: Searches of non-psychiatric journals*²

The search was first undertaken within some individual medical journals:

- (i) *The British Medical Journal* [*M-1(i)*];
- (ii) *The Lancet* [*M-1(ii)*]; and
- (iii) *The New England Journal of Medicine* [*M-1(iii)*].

And then within medical databases:

- (iv) PubMed [*M-1(iv)*]; and
- (v) MEDLINE [*M-1(v)*].

M-1(i): The British Medical Journal

A search of the *British Medical Journal* between January 1994 and July 2008, for the term ‘*psychiatric misdiagnosis*’ occurring anywhere in a journal article, retrieved just one article;³ it concerned the misdiagnosis of ‘*conversion symptoms*’⁴.

¹ *I.e.* the search term was “*psychiatric AND misdiagnosis*”.

² Searches were conducted between 3 and 10 September 2008.

³ Stone (2005).

Searches for the terms “*psychiatric mis-diagnosis*”; “*psychiatric under-diagnosis*”; “*psychiatric underdiagnosis*”; “*psychiatric over-diagnosis*” or “*psychiatric overdiagnosis*” retrieved no results.

⁴ *I.e.* physical symptoms diagnosed as being of psychiatric origin.

A search for “*psychiatric AND misdiagnosis*” retrieved 24 results; of those results which had some relevance to psychiatric misdiagnosis:

- 8 concerned the misdiagnosis of conversion symptoms;
- 3 discussed the misdiagnosis of physical illness (*e.g.* epilepsy) as psychiatric;
- 1 discussed whether the high diagnosis of psychiatric illness amongst immigrant communities, could be attributed to misdiagnosis;
- 2 were news items reporting the rapid increase (“*40-fold from 1994 to 2003*”)⁵ in the diagnosis of bipolar disorder and whether this indicated extensive misdiagnosis.

M–1(ii): The Lancet

A full text search of the *Lancet* series of journals for use of the term ‘*psychiatric misdiagnosis*’ between January 1996 and January 2008 retrieved no results.

A full text search for ‘*psychiatric AND misdiagnosis*’ over the same period retrieved 26 results, the most common topic being epilepsy (3 results) followed by chronic fatigue syndrome (2 results). Only one result had a general relevance to psychiatric misdiagnosis and its author (a consultant psychiatrist who had worked at Ashworth Maximum Security Hospital) detailed how his attempt to introduce non-pharmacological psychiatric treatments had been frustrated by other psychiatrists:⁶

... [these] psychiatrists are not alone in misdiagnosing all mental disease – contemporary psychiatry takes its cue from *DSM-IV*, bizarrely presuming, against all the evidence, that social and emotional stress, even the death of a loved one, have no impact on mental disease. The horrors from this misdiagnosis exceed even those from the Ashworth variety – and are harder to remedy, given the level of support for it among government departments and medical editors.⁷

M–1(iii): The New England Journal of Medicine

A full text search for occurrences of the term ‘*psychiatric misdiagnosis*’ in articles published between September 1993 and September 2008, retrieved no results.

A full text search for “*psychiatric AND misdiagnosis*” retrieved 9 results the most common topic being ADHD (2 results); none were relevant to estimating levels of psychiatric misdiagnosis.

⁵ Tanne (2007).

⁶ Johnson (1999):

The 15 consultant psychiatrists showed their managerial power by having us both removed ... It was only when the so-called treatment-resistant patients insisted on attending every group session, as did the Head of Psychology herself, that the consultant staff cited General Medical Council guidelines and the Mental Health Acts to expel me. The consultants deflected patients from the very door of the group therapy sessions, denying them entrance.

⁷ *Ibid.*

M-1(iv): PubMed

A full text search for 'psychiatric misdiagnosis' retrieved 12 results, the most relevant were:

- the misdiagnosis of physical or neurological illness as psychiatric (5 results);
- analyses of cases of psychiatric misdiagnosis (4 results);⁸
- misdiagnosis of Black patients (1 result).

A search for 'psychiatric AND misdiagnosis' retrieved a further 270 results of which 42 had some relevance to psychiatric misdiagnosis. Of these results,

- 8 related to technical misdiagnosis;⁹
- 7 related to the misdiagnosis of physical illness as psychiatric;¹⁰
- 1 concerned deliberate misdiagnosis of depression.
- 12 examined race as a cause of misdiagnosis¹¹ and
- 13 examined other causes, some of which have already been discussed.¹²

Of the remaining relevant studies, one argued that:

Recent research has raised concerns about the adequacy of psychiatric diagnostic evaluations conducted in routine clinical practice. Semistructured diagnostic interviews have been considered the diagnostic gold standard. Judged against this standard, studies comparing unstructured clinical evaluations with semistructured interviews have found that there is a high rate of missed diagnoses and misdiagnosis using the usual clinical assessment. Whether this is clinically significant is uncertain because there are no studies that have examined whether the use of standardized research interviews improves clinical outcome.¹³

A second examined the social causes of psychosis and concluded that:

The relation between the etiology of psychosis and such social factors as poverty, migration, and racial discrimination has been neglected in the North American psychiatric literature for the last 40 years. ... the study of social causes of psychosis has been replaced by a focus on the clinical encounter, in which

⁸ Khan & Shaikh (2008) examined four case reports in an attempt to isolate the factors contributing to psychiatric misdiagnosis; one such factor was the "excessive reliance on the expertise of specialists." The authors emphasised "the need to challenge and correct erroneous diagnoses to avoid inadequate response".

The other three papers were by Israeli researchers on psychiatric misdiagnosis: Witztum (1992), Margolin (1995) and Witztum (1995a). (See *supra*)

⁹ E.g. bipolar disorder misdiagnosed as unipolar depression.

Instances of misdiagnosis of schizophrenia in place of affective disorders, have not been classified as 'technical' because the diagnoses are qualitatively different when viewed from the perspective of assessing the risk of stigma, dangerousness or coercive intervention. [See *infra* and Chapter 4].

¹⁰ E.g. Reeves (2000) who examined the cases of 64 patients with unrecognized medical emergencies who were inappropriately admitted to psychiatric units, concluded that:

In none of the cases (0%) was an appropriate mental status examination performed. Other common causes of misdiagnosis included inadequate physical examination (43.8%), failure to obtain indicated laboratory studies (34.4%), and failure to obtain available history (34.4%).

¹¹ The existence of a possible link between race and misdiagnosis is contentious [see *infra*].

¹² E.g. Witztum (1995a).

¹³ Zimmerman (2003).

clinician bias is presumed to be responsible for widespread misdiagnosis of psychosis in minority ... populations.¹⁴

A standpoint which if adopted, might help dispel some of the confusion that surrounds the debate on race and psychiatric misdiagnosis (*supra*).

M-1(v): MEDLINE

A full text search for the term '*psychiatric misdiagnosis*' between 1979 and 2007 yielded 9 results;¹⁵ these added little to the results already obtained.

The search for '*psychiatric AND misdiagnosis*' between 1996 and 2007 yielded 129 results; as an analysis of these added little to earlier results, no searches were made prior to 1996.

M-2: Searches of psychiatric journals¹⁶

Searches were made of two authoritative journals:

- *The American Journal of Psychiatry* [M-2(i)]; and
- *The British Journal of Psychiatry* [M-2(ii)].

for occurrences of the term '*misdiagnosis*'¹⁷ firstly in the title or abstract, and secondly, anywhere in the text.

M-2(i): The American Journal of Psychiatry

A title or abstract, search for '*misdiagnosis*' between 1844 and 2008, yielded 19 results.¹⁸ Though none of the studies yielded information sufficient to estimate rates of misdiagnosis (whether general or specific) some did give an insight into the misdiagnosis of schizophrenia:

¹⁴ Jarvis (2007).

¹⁵ More accurately:

- 1975–1979: none;
- 1980–1984: 1 [racism];
- 1985–1988: 1 [psychiatric misdiagnosis of *myasthenia gravis* (muscle weakness)];
- 1989–1990: none;
- 1991–1995: 5 [3 Witztum papers (*supra*), misdiagnosis of *myasthenia gravis* and of cystitis];
- 1996–1999: 1 [racism];
- 2000–2002: none;
- 2003–2007: 2 [racism].

¹⁶ Searches were conducted on 11 September 2008.

¹⁷ Being psychiatry journals, a search for '*misdiagnosis*' was considered to be more appropriate than one for '*psychiatric misdiagnosis*'.

¹⁸ Of which:

- 3 were 'Letters to the Editor';
- 3 were book reviews;
- 4 concerned technical misdiagnosis;
- 2 discussed misdiagnosis and race;
- 7 concerned the misdiagnosis of schizophrenia.

Example (i): It appears from these data that black and Hispanic ... bipolar patients may be at a higher risk than whites for misdiagnosis as schizophrenic ...¹⁹

Example (ii): Two groups of inpatients who were initially misdiagnosed are described. The pseudoschizophrenics showed little affect and had histories of exotic and sensational behavior; the initial misdiagnosis of schizophrenia appeared to be a moral censure.

The pseudoneurotic schizophrenics (mistakenly diagnosed at admission as nonschizophrenic) had more affect and were frequently pregnant, affiliated with the medical profession, or twins; these diagnostic mistakes appeared to be attempts to protect someone from the label of schizophrenia.²⁰

Example (iii): In the Amish Study of affective disorders, 79% of the 28 active bipolar I patients, ... previously had received hospital record diagnoses of schizophrenia.²¹

A full text search for 'misdiagnosis' yielded no additional results.

A full text search for 'misdiagnosis AND "compulsory admission"' yielded 3 results of which 1 had no relevance,²² both of the remaining concerned race; of these, one discussed the advisability of "*matching clients from a minority group with clinicians from the same ethnic background*"²³; the second²⁴ was a meta-analysis which found that the relative risk of schizophrenia in immigrant communities was 4.8 times that of non-immigrants; it did not, however, give credence to the possibility of misdiagnosis as being a possible cause.²⁵

M-2(ii): The British Journal of Psychiatry

A title or abstract search for 'misdiagnosis' yielded 13 results;²⁶ of most interest in the present context was an especially authoritative²⁷ survey of UK psychiatrists as to whether they believed that race contributed to psychiatric misdiagnosis.²⁸ It concluded that:

¹⁹ Mukherjee (1983).

²⁰ Schorer (1968).

²¹ Egeland (1983).

²² The context was: "*This interview was compulsory for all potential living kidney and kidney/pancreas recipients.*"

²³ Ziguras (2003).

²⁴ Cantor-Graae (2005).

²⁵ *Ibid.*, p.20:

Some researchers have argued that migrants preferentially receive schizophrenia diagnoses because of cultural misunderstanding and/or language difficulties ... Nevertheless, evidence in support of this notion is not convincing.

It did, however, canvass the possibility that the experience of racial discrimination possibly "*facilitates the development of psychotic symptoms*". (p.21).

²⁶ Of these results, 4 discussed the possible link between misdiagnosis and race; 4 examined the misdiagnosis of a physical illness as psychiatric; 1 discussed a technical misdiagnosis.

²⁷ Each member of the Royal College of Psychiatrists in the UK was canvassed and 43% participated.

²⁸ The opening sentence of the report: "*Stigmatisation of people with mental illness, especially schizophrenia, seriously affects their lives by its effects, for example on job prospects and relationships.*" [*Ibid.*, p.401] provides some justification for the decision taken earlier in this discussion to distinguish between a 'technical misdiagnosis' and the misdiagnosis of schizophrenia.

Misdiagnosis of schizophrenia in Black people is believed to be common²⁹ ... This may be surprising in view of research studies, which have suggested such misdiagnosis to be uncommon (Harrison *et al*, 1988), but accords with the views of many patient groups and some recent research (Hickling *et al*, 1999). It is possible that such studies using standardised instruments are seen by psychiatrists as not being typical of 'normal' clinical practice where such misdiagnosis may be more common.³⁰

The dichotomy noted between research findings and clinical perceptions of misdiagnosis, raises the question – particularly because the survey was so authoritative – as to whether other research findings on psychiatric misdiagnosis underestimate the phenomenon.

A full text search for '*misdiagnosis*' yielded 172 results; whilst some discussed instances of physical disorders misdiagnosed as psychiatric (*e.g.* Huntington's Chorea) and some examined small studies of technical misdiagnosis, none – with the exception of 25 results which discussed racial factors – had any immediate relevance to the problem of estimating general rates of psychiatric misdiagnosis. The studies on misdiagnosis and race focused mainly on whether the high rates of diagnosis of schizophrenia found in the Afro-Caribbean population in the UK, was evidence of misdiagnosis.

Searching within these 172 results for those which discussed '*compulsory admission*' yielded 9 results, 6 of which³¹ concerned race as a cause of psychiatric misdiagnosis.

Amongst these papers there is broad agreement on a number of propositions:

1. The existence of disproportionately high rates of compulsory admission amongst Afro-Caribbeans and Blacks when compared to Whites.³²
2. The existence of disproportionately high rates of schizophrenia amongst Afro-Caribbeans and Blacks when compared to Whites.³³

²⁹ 47.9% of respondents '*strongly agreed/agreed*' that misdiagnosis of schizophrenia in Black people is common whereas 25.1% '*strongly disagreed/disagreed*'.

³⁰ Kingdon (2004).

³¹ The remaining 3 were:

- (i) Porter (2001) which concerned non-pharmacological treatment of depression;
- (ii) Clark (2001) which examined the treatment of adolescent psychosis; and
- (iii) Davison (2002) which discussed managing patients with personality disorder.

³² Singh (2007): "*Black patients were 3.83 times ... more likely to be detained.*"

³³ Bhugra (2001) cites studies showing rates of schizophrenia amongst African-Caribbeans as between 2 and 14.6 times that of their White counterparts. (p.286).

See also De Vries (1995) who in discussing South Africa, stated:

Audit of community psychiatric clinics, however, showed strange figures: "*Schizophrenia was diagnosed in 68% of black patients compared with 19% of white patients; mood disorders were diagnosed in 9% of black patients compared with 41% of white patients.*"

He also posed the following questions:

What criteria have been used to make the diagnosis? By whom were the diagnoses made? ... Is it not a sign of wisdom for rural black people to "hear voices" or "see vision" of their forefathers?

3. The raised rates of compulsory admission were largely attributable to increased rates of schizophrenia.³⁴

The question of whether the disproportionately high rates of diagnoses of schizophrenia amongst Afro-Caribbeans and Blacks (and the corresponding high rates of compulsory admission) could be accounted for by misdiagnosis due to an (unconscious) racial prejudice amongst psychiatrists,³⁵ was generally discounted:

(i): Bebbington (1994) concluded: “*Ethnicity did not appear to be of outstanding importance in decisions to use the Mental Health Act.*”

(ii): Singh (2007) concluded: Although BME³⁶ status predicts psychiatric detention in the UK, most explanations offered for the excess detention of BME patients are largely unsupported.”

(iii): Harvey (1990): “... [this study] does not support the hypothesis that misdiagnosis within the psychoses can explain the higher admission rates of schizophrenia calculated for Afro-Caribbean populations.”

(iv): Sharpley (2001): “No simple hypothesis explains these findings.”

(v): Bhugra (2001): “However, misdiagnosis alone cannot explain all the findings in both the USA and the UK.”³⁷

The conclusions that might be drawn from these search results are discussed in Chapter 4, Section D.

³⁴ Thomas (1993):

In the Afro-Caribbean group, the raised rates of admission were largely attributable to increased rates of schizophrenia. The highest rate occurred in second-generation (UK-born) Afro-Caribbeans and was nine times that among Europeans.

See also Bebbington (1994): “... admission under the Act was strongly associated with challenging behaviour and diagnosis of schizophrenia.” ...

³⁵ See Luhrmann (2010) who notes that in the 1980s:

African American men came to represent the problem of schizophrenia in popular culture and, arguably, in psychiatry. Advertisements for antipsychotic medications in the psychiatric journals showed angry black men or even just African tribal symbols. (p.479)

³⁶ I.e. Black and minority ethnic groups

³⁷ *Op. cit.*, p.285.

Appendix N: Journal searches for occurrences of ‘irrational(ity)’

Of the various journal searches for occurrences of the term ‘irrational’ (which have been detailed in Chapter 2, Section B) the smallest set of search results (6) was for the *British Journal of Psychiatry* and – in order to convey a ‘flavour’ of the general results – this complete set is listed in Subsection N–1.

Subsection N–2 contains an analysis of the aggregated results of all the journals which were searched.

N–1: The British Journal of Psychiatry: complete listing

A search for occurrences of either ‘irrational’ or ‘irrationality’ in title or abstract³⁸ between October 1855 to December 2009, yielded 6 results:³⁹

[In the interests of readability, occurrences of ‘irrational’ or ‘irrationality’ are underlined.]

1. Philpot, M. *et al* (2001). ‘The use of operationalised criteria for inclusion on a Care Programme.’ *Psychiatr. Bull.* 25: 172 – 174.

Health service policies exist to reduce variation in clinical practice and to ensure minimum standards. Clinical audit may be a useful tool in identifying irrational variation within the framework of clinical governance.

2. Anderson, D. (1989). ‘A comparison of in-patient and out-patient prescribing.’ *The British Journal of Psychiatry.* 154: 644 – 649.

This suggests that psychiatrists do not adopt intransigent stances in favour of polypharmacy and irrational psychotropic prescribing, as previous studies have implied. Caution is advised before attributing apparently irrational prescribing to bad clinical practice, or advocating remedial action aimed at changing the habits of prescribers.

3. McKerracher, D. *et al* (1968). ‘Self-Mutilation in Female Psychopaths.’ *The British Journal of Psychiatry.* 114: 829 – 832.

It may be that the acts of self-mutilation and window-smashing have a ceremonial quality. There would certainly seem to be a compulsive element in the repetitive and irrational manner of their perpetration ...

4. Kräupl, F. (1948). ‘Some Observations on the Analytical Group Treatment of a Phobic Patient.’ *Journal of Mental Science.* 94: 77 – 88.

The psychosexual constitution of the patient and his response to the group were unusually transparent. He showed marked anal-erotic, sado-masochistic, and bi-sexual trends with repressed passive homo-erotic impulses. The result of group treatment was mainly limited to a correction of irrational social fears through the reduction of guilt feelings and the gradual acceptance of his passive-feminine and masochistic leanings.

5. Stengel, E. (1941). ‘On the Aetiology of the Fugue States.’ *Journal of Mental Science.* 87: 572 – 599.

³⁸ Full text searches over the same period, yielded 652 results for ‘irrational’ and 87 for ‘irrationality’.

³⁹ The results are listed in reverse chronological order.

Certain types of behaviour akin to wandering states occur in children in whom there is a disturbance of home conditions similar to what has been noted in this paper. A tendency towards rationalization and sublimation indicates in some cases the effort to oppose the irrational urge. ... to find a compromise between the irrational impulse and rational strivings.

6. Unsigned (1902). 'Epidemic Irrationality: an American City of Unreason.' *Journal of Mental Science*. 48: 542-543

... such an extensive outburst of irrationality, that it really calls for grave consideration.

In that these results comprise the complete listing of all 'Title/Abstract' occurrences (over a period of 154 years) of the term 'irrational', in the leading UK clinical psychiatric journal, they clearly exhibit a less than full understanding of the nuances of the term and a lack of precision in its usage. The following analysis will help determine the generalizability of this conclusion.

N-2: Analysis of the aggregated search results of all journals

The aggregated search results were analysed under a number of headings as shown in the tables in *N-2(i)*. Examples of individual search results as categorised under the various headings are given in *N-2(ii)*.

N-2(i): Tables

The headings were suggested by a preliminary scrutiny of the search results; the examples given in *N-2(ii) (infra)* will give an indication of the meanings of the various categories that were adopted.

<u>Category</u>	<u>Number</u>
Colloquial	41
Emotion	12
Management	10
Philosophy (General)	12
Philosophy (Psychiatry)	23
Phobia / Fear	8
Polypharmacy	7
Psychiatric	9
Psychotherapy	8
Society	18
Suicide	15
Treatment Refusal	1
Treatments	17
<i>Total:</i>	<i>181</i>

Table N-1: Analysis of journal search results by category

<i>Precision rankings</i>	<i>Number</i>
* (low)	105
**	42
***	15
****	16
***** (high)	3
<i>Total:</i>	<i>181</i>

Table N-2: Analysis of journal search results by precision

<i>Coercion indicated</i>	<i>Number</i>
Yes	12
No	169
<i>Total:</i>	<i>181</i>

Table N-3: Analysis of journal search results by coercive context

N-2(ii): Examples⁴⁰

Examples of categorisation are given in N-2(ii)(a); examples of precision rankings are given in N-2(ii)(b) and examples of coercion rankings are given in N-2(ii)(c).

Two examples are given of all categories and rankings.⁴¹

N-2(ii)(a): Examples of categorisation

- Colloquial

Example (i): Thomas Kuhn was criticized for allegedly suggesting ... that scientific decisions regarding theory choice, interpretation of data, and the like were determined by "mob psychology" or similar irrational sources.⁴²

Example (ii): One autumn evening when the university corridors were deserted, an irrational-seeming male student whom I did not recall having seen before, asked if he could speak to me.⁴³

- Emotion

Example (i): French sociologist who viewed punishment as an irrational emotional reaction driven by a culture's desire to maintain ...⁴⁴

Example (ii): ... a mother crazed with the stressors of incomprehensible behaviors, controversial professional advice, minimal support, and irrational guilt.⁴⁵

- Management

Example (i): There is much that is inconsistent and irrational in the present methods of training surgeons.⁴⁶

⁴⁰ Page numbers for some examples could not be readily determined from the search results.

⁴¹ Except for 'Treatment Refusal' for which only one example was found

⁴² Sadler (1996).

⁴³ Code (1996).

⁴⁴ Kaempf (2009).

⁴⁵ Lefley (2006).

⁴⁶ Ravdin (1957).

Example (ii): The authors believe this experience demonstrates that political factors can overwhelm standard clinical practice and reasoned health planning to force irrational change on health care delivery.⁴⁷

- Philosophy (General)

Example (i): ... arguments based on Kantian conceptions of autonomy are rejected as confused, and preference is given to Millian arguments based on the right to make decisions about one's own life, however irrational, as long as they do not harm others. In light of this discussion, it is argued that mentally disordered people cannot be denied this right on grounds of their 'irrationality', which is anyway a vague concept with several meanings.⁴⁸

Example (ii): The problem shows up very clearly, interestingly enough given the present context, in Davidson's application of the theory to the phenomena of irrationality. Irrationality is explicated in terms of the causal efficacy of a reason overriding rational principles ...⁴⁹

- Philosophy (Psychiatry)

Example (i): He tackles the crucially important issue of how practical rationality is related to mental health and of how certain forms of irrationality are connected with mental illness.⁵⁰

Example (ii): The history and present practice of psychiatry, as well as much ordinary moral thinking, is replete with examples of discounting some desires of patients on grounds of their supposed irrationality, a discounting which often, upon inspection, comes to little more than the evaluator disagreeing with the patient about what should be desired in the circumstances in question. Grounds for judging desires as intrinsically irrational, or as intrinsically less rational than other desires (as opposed to instrumentally irrational in achieving agreed upon ends), are notoriously unclear and controversial.⁵¹

- Phobia / Fear

Example (i): Such a model will need to take account of the intuition that, for example, people who are paralyzed by irrational fear, ... may not be in the ideal position to make medical decisions ...⁵²

Example (ii): A lasting psychological result from the accident is an irrational fear that while driving or bicycling, a car or truck will suddenly swerve into my path.⁵³

- Polypharmacy

Example (i): We are all aware that polypharmacy is a common practice – eminently rational when we engage in it but blatantly irrational in the hands of others.⁵⁴

⁴⁷ Hogben (1979).

⁴⁸ Matthews (2000).

⁴⁹ Bolton & Hill (1997).

⁵⁰ Fields (1996a).

⁵¹ Brock (1998).

⁵² Elliot (1998).

⁵³ Ship (2004).

⁵⁴ Jefferson (2003).

Example (ii): However, irrational polypharmacy occurs too frequently. Examples include the use of several benzodiazepines or several antipsychotics at the same time.⁵⁵

- Psychiatric

Example (i): The authors conclude that the experience of volitional control in patients with OCD [obsessive-compulsive disorder] is not significantly related to the level of insight they have into the irrationality of their behavior.⁵⁶

Example (ii): During the last decade there has been increasing pressure to legislate legal rights for psychiatric patients especially in relation to consent to treatment. The attempt to subject the irrationality of psychotic illness to the due process of rational laws has caused problems.⁵⁷

- Psychotherapy

Example (i): Discussion groups of various kinds have been called "group psychotherapy." This irrational practice is illustrated and discussed.⁵⁸

Example (ii): ... very concept of therapeutic alliance involves contradiction – namely, the expectation that the patient is motivated to be rational about his or her own irrationality.⁵⁹

- Society

Example (i): Belief systems which may be just as irrational but which are shared by millions are called world religions.⁶⁰

Example (ii): ... notion that climate change is an impending problem, the fear of nuclear power and radiation is perhaps based on ignorance and irrationality.⁶¹

- Suicide

Example (i): And the law in England makes clear that a person can refuse treatment for no reason or for an irrational reason ... But perhaps in practice, one reason why physicians do not respect the preferences of people like John and Ron is that they believe that such patients are irrational in desiring to die. Are such preferences irrational? In philosophy and economics, a dominant school maintains that there is only one form of rationality: instrumental rationality. According to this school, we are only irrational if we choose means which are inappropriate to our ends. Neither John nor Ron is irrational in this sense. Is John's choice intrinsically irrational?⁶²

Example (ii): The author's literature survey suggests that the incidence of suicide among psychiatric residents ... During their residencies psychiatrists

⁵⁵ Kingsbury (2002).

⁵⁶ Rotter & Goodman (1993).

⁵⁷ Draper & Dawson (1990).

⁵⁸ Pinney (1965).

⁵⁹ Lindy (2000).

⁶⁰ Storr (1997).

⁶¹ Kotchen (2008).

⁶² Savulescu & Dickenson (1998a).

should be helped to prepare themselves to endure the irrationalities of their patients and the burden of isolation in their professional practice.⁶³

- Treatment Refusal

Example (i): Twelve renal homotransplantation donors were interviewed in depth between five weeks and 18 months after surgery. Unexpected findings were (1) the decision-making process about donorship did not at all follow a pattern compatible with the concept of "informed consent" but occurred as an instantaneous, irrational response which subsequently was justified and maintained with the aid of a number of defensive techniques;
...⁶⁴

- Treatments

Example (i): Contemporary biological psychiatry is in a seemingly inchoate state. I assert that this state of biological psychiatry is due to its violation of an epistemological criterion of rationality, *i.e.*, the relevance criterion; that is, contemporary biological psychiatry is irrational as it adopts a conception irrelevant to the psychobiological domain. This conception is mechanistic. The irrationality of biological psychiatry is manifest as the dominance of neurochemical explanations of psychopharmacological correlations, resulting in predictive sterility and, correspondingly, in the dominance of serendipity.⁶⁵

Example (ii): Meprobamate: A Study of Irrational Drug Use.

The history of the tranquilizer meprobamate illustrates how factors other than scientific evidence may determine physicians' patterns of drug use. Forceful advertising and publicity, an attitude of general optimism, and uncontrolled studies with favorable results combined to elevate meprobamate to the position of America's magical cure-all tranquilizer. This drug remains in wide use despite a large body of sound scientific data that questions its efficacy.

N-2(ii)(b): Examples of precision rankings [(low) to ***** (high)]*

*

Example (i): When a group therapy program is instituted on a psychiatric service ... It exposes as diversionary maneuvers by various group members irrational distortions of the administrative physician as a surrogate authority.⁶⁶

Example (ii): Some psychiatrists allege that the death fear (whether on the battlefield or in the death house) serves as an irrational surrogate for some other fear – such as castration.⁶⁷

**

Example (i): Hence, I can accommodate eccentric, irrational or even "crazy" moral beliefs like that of Duff's split-infinitive fanatic. A person can have irrational factual beliefs; why not irrational moral beliefs?⁶⁸

⁶³ Kelly (1973).

⁶⁴ Fellner & Marshall (1968).

⁶⁵ Rudnick (1990).

⁶⁶ Cruvant (1953).

⁶⁷ Bluestone & McGahee (1962).

Example (ii): The clinical manifestations of PD [Parkinson's disease] depression include apathy, psychomotor retardation, memory impairment, pessimism, irrationality, and suicidal ideation without suicidal behavior.⁶⁹

Example (i): The definitions seem to be stating the degree of irrationality or abnormality necessary to invalidate deeds or to require action by society.⁷⁰

Example (ii): He tackles the crucially important issue of how practical rationality is related to mental health and of how certain forms of irrationality are connected with mental illness.⁷¹

Example (i): Delusion, then, has traditionally been presented as synonymous with irrationality (absurdity, groundlessness, error, chaos), whereas by contrast its mirror image, reason, has been defined in terms of evidence, demonstrability, truth and order. I will analyse and contrast their paradoxical definitions.⁷²

Example (ii): The ubiquitous nature of irrational thought in nonpathological states is acknowledged; "*We are all—even the most insightful among us—holding a great many false beliefs at any moment.*" Irrationality is defined as pathological only when it obstructs an individual's ability to realize important life goals.⁷³

Example (i): As he points out, the paradox of irrational actions or beliefs is that they are failures within the space of reasons. If they were simply non-rational they would lie outside the sphere of rationality completely and would not be paradoxical. But irrational acting or thinking is subject to reason explanation and thus subject to the in-built rationality that that form of explanation carries. They are, however, subject to merely partial reason explanations, reason explanations which fail to be fully rational. The philosophical difficulty is to account for this half way house.⁷⁴

Example (ii): I do have reservations about the way in which Bolton and Hill use intentional predicates and whether the intentional stance is as successful for irrational behavior as they need it to be. Once they have used the intentional stance for irrational behavior, does it still have the predictive force that it is supposed to? Bolton and Hill state, "*If a person believes such-and-such, then she must, in appropriate circumstances, act in a way that accords with that belief*" ... They note, correctly, that the force of the word must derives (if it does at all) from the assumption of rationality. They suggest that irrational behavior may likewise be predicted by adding *ceteris paribus* clauses that account for variation away from the norm.⁷⁵

⁶⁸ Fields (1996b).

⁶⁹ Slaughter (2001).

⁷⁰ Mezer & Rheingold (1962).

⁷¹ Fields (1996a).

⁷² Bodei (2005).

⁷³ Trevino (2008).

⁷⁴ Thornton (1997).

⁷⁵ McMillan (1999).

N-2(ii)(c): *Examples of coercion rankings*

- Yes

Example (i): John Burnside considers that suicidal intent is "*prima facie evidence of disease of the mind*," and that "irrationality with intent to kill the self" justifies the force of the law and an ethical duty of psychiatrists to prevent suicide ...⁷⁶

Example (ii): My contention of *prima facie* status extends to their discussion about competence and autonomy. Irrationality, I agree, does not amount to incompetence, but irrationality with the intent to kill a self justifies the force of law and the maximum requirements of psychiatrists ...⁷⁷

- No

Example (i): ... insistence on all possibly beneficial care worsens this toxicity. Good mediation technique can help to clarify misunderstandings, soften anger, and ease irrational distrust.⁷⁸

Example (ii): So when Halpern explains repeatedly that emotions are irrational – a common view dating back to Plato – it is not very useful.⁷⁹

⁷⁶ Burgess & Hawton (1998b).

⁷⁷ Burnside (1998).

⁷⁸ Bloche (2005).

⁷⁹ Cassell (2002).

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