

## CHAPTER TWELVE

# A Metaphysical and Epistemological Critique of Psychiatry

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*Current health care standards, in many countries, Australia included, are regrettably poor. Surprisingly, practitioners and treating teams alike in mental health and disability sectors, in particular, make far too many basic care-related mistakes, in addition to the already abundant diagnostic mistakes that cause and amplify great harm. In part, too many practitioners also fail to distinguish adverse effects for what they are and all too often treat adverse effects, instead, as comorbidities. Diagnostic failures are dangerous, the result of which generates and perpetuates harms that are extremely costly in terms of patient welfare, in addition to the financial burden placed on everyone. In this essay, I contend that the authority bestowed upon psychiatry is misplaced. Subsequently, this misplaced authority affects the governing and investigatory institutions reliant and informed by psychiatry. The examination process undertaken in this investigation traces the metaphysics of psychiatric disorders relative to the Diagnostic-Statistical-Manual (DSM) in all its iterations and to the epistemological construction process that serves to underpin the fundamentals of psychiatric practice. There exists a crisis of confidence in psychiatric practice and I urge drastic reform be undertaken to arrest the damage.*

**Keywords:** *Psychiatry, Diagnostic-inflation, Polypharmacy, Methodological-deficiency, Drug-induced-adverse-effects.*

### Introduction

Current standards of Health Care concerning mental health, aged care, and disability sectors, are extremely poor and severely deficient warranting Royal Commissions recently in Australia. Poor standards involving diagnostic inflation, polypharmacy, questionable use of restrictive practices, abuse, segregation and exploitation. There are those fortunate enough to have good care, good carers and good clinical practitioners in the mix. ‘It’s not a total mess’, some might say! Yet, the very nature and shape of mental health and disability relative to the associated services has been influenced largely by psychiatry seemingly without enough regard for the inherent methodological problems bedeviling it as a clinical practice. All fields of medicine are fallible, some more than others are subject to

inexact practices weakened by their own theoretical and methodological deficiencies. Psychiatry, for its presumed authority, however, is a special case in point that requires specific attention. The literature emerging within the ranks of psychiatry, collectively, and aptly named Critical Psychiatry, testifies to the internal concerns regarding the profession and its practice disclosing serious methodological deficiencies. What is not generally made public is the number of individuals who have lost their lives as a direct consequence of poor clinical, often coerced, psychiatric drug-centred treatment and mismanagement. In America, according to Psychiatrist Allen Frances, there were more deaths “due to legal prescription drugs than from illegal street drugs” (2013, p. xv). We should note that Frances played an integral role in the development of the Diagnostic and Statistical Manual (DSM), specifically DSM-III, DSM-III-R and DSM-IV. In Australia, as reported by the Australian Bureau of Statistics (ABS) (2018) ‘3303.0 Causes of Death, Australia, 2016 Report’ released 15 May 2018, suicide statistics are on the rise and though several socioeconomic factors are involved mental illness as constructed and conveyed from within psychiatry permeates our social psyche and its memes penetrating all areas of human interaction. These worrying suicide trends are worst in the United States where it is legal for the Pharmaceutical industry to market directly to consumers. Risk of overdose increases when individuals take both benzodiazepines and opioids yet despite the risk, “rates of coprescribing nearly doubled, increasing from 9% in 2001 to 17% in 2013” (Lembke, Papac, and Humphreys, 2018, p. 694). Psychiatry, by and large, presupposes that:

generalizable psychopathological entities exist that can be demarcated and that individuals who are categorized in a particular way share much in common with others who are assigned the same diagnosis. It assumes that mental disorders can be characterised independently from other characteristics of the individual who is affected. This was and is a hypothesis (Moncrieff & Steingard, 2019, p. 4.).

Vast cultural diversity and immeasurable variation among individuals makes such reductionist assumptions challenging to verify, among an array of other epistemic challenges. Yet in practice, this ill-conceived assumption nonetheless largely underpins general psychiatric clinical and prescriptive practices. Complications emerge as echoed by Johann Hari’s research published in 2018 *Lost Connections: Uncovering the Real Causes of Depression and the Unexpected Solutions*. Hari draws upon empirical research and presents these findings in an accessible manner. When it comes to depression psychiatrists do understand that the causes can be wide and varied. Some people experience depression due to environmental, social and psychological concerns, as such are classified as “reactive depression”. Others, experience depression due to internal physical concerns, as such are classified as “endogenous depression” (Hari, 2018, p. 52). Hari describes a clinical trial that involved a comparative analysis of two groups: a group diagnosed with ‘reactive depression’ and a group diagnosed with ‘endogenous depression’, evidently, the result was: ‘no difference between them’. One common factor was discovered between the two defined groupings; the

common factor was ‘trauma’ and the “generalisation of hopelessness” featured as a distinctive variable. Repeated clinical trials, as Hari reports, undertaken some years later to investigate the causes of depression in places radically different as rural Zimbabwe and rural Spain, produced the same findings. In sum, where there exist strong community ties, like rural Spain, depression is very low, consistent with people who have less traumatic experiences and, in such community’s, this acts to protect people against depression. In contrast, in areas where trauma is high, community ties withered, as then rural Zimbabwe, it was found that these factors were driving depression (Hari, 2018, p. 52).

As such, in this essay I examine the nature of mental health disorders as distinguished between ‘endogenous’ (predisposed/genetic) and ‘reactive’ forms by interrogating the ontology of mental disease/disorders, the psychosocial and psychosomatic mechanisms of symptom manifestation, coupled with an examination of the epistemological mechanisms commonly employed by psychiatrists when constructing diagnostic claims regarding the nature of mental disease/disorders that will ultimately affect treatment options. To this end, I provide a brief review of the practice of diagnosis and the continuing attendant substantiation problems, specifically verification, validity, and reliability of diagnosis, as associated with psychiatry. What ensues are six main points of concern identified as ‘over-diagnosis’ or ‘diagnostic-inflation’, ‘polypharmacy’, ‘harm perpetrated by clinical mismanagement’, ‘harm by coercion’, mistaking ‘trait’ for ‘state’, and referring to ‘adverse effects as comorbidities’. These concerns are bi-products arising from methodological deficiencies bedeviling psychiatry made worse by misguided clinical practitioners. I conclude that the ‘curse of expertise’ (Robson, 2019) and the misplaced authority afforded psychiatry contributes, whether by design or accident, towards the exacerbation of disability and mental-health social ills. This misplaced authority indeed errantly legitimates the ill-conceived narratives, as propagated through its Diagnostic-Statistical-Manual (DSM) in all iterations, psychiatry’s detailed construction and list of disorders and their proffered treatments largely influenced by the outreach of the pharmaceutical industry (Frances, 2013; Whitaker, 2015; Steingard, 2019).

### *Psychiatry: What is it all about?*

Debate regarding the etiology and treatment of major mental disorders, a debate with a long history, still rages between biological psychiatry and psychological psychiatry (Preston and Johnson, 2019, p. 1). Historically, in tandem with the influential growth of DSM-III Diagnostic system, was an increasing application and administration of drug treatments in line with ‘psychiatric diagnostic inflation’ (Frances 2013). This adaptation became the primary therapeutic mode of psychiatry. Heavily influenced by the pharmaceutical industry, the prevalence of drug treatments contributed to the conceptual legitimacy of psychiatry as a medical branch under the impression it was sustained by having delineated pathological conditions targetable by using disease-specific treatments, as in medicine” (Moncrieff & Steingard, 2019, p. 4). For example, in the United States “since 2005 there have been a remarkable eightfold increase in

psychiatric prescriptions among our active duty troops”. In the general population, “antidepressant use nearly quadrupled from 1988 to 2008 (Frances, 2013, p. xv). Worryingly, far too many problems associated with psychiatry are rampant. In practice, during an examination the clinician should be considering to what extent the presentation of a patient/client with some concern is due to psychological factors (reactive), and if so, mostly does not require drugs for treatment, or to what extent the concern is due to an endogenous (genetic) disturbance in which case often drugs may be required. (Preston and Johnson, 2019, p. 1). This is the general area where the controversy largely lies whilst also generating reason for the crisis of confidence in psychiatry for so often, in the diagnosis stage, serious decision-making errors are made and that leads to patient/consumer mismanagement. Similarly, in the United States there is little effort:

to address inappropriate prescribing of benzodiazepines – controlled substances such as alprazolam, clonazepam, diazepam, and lorazepam. The Food and Drug Administration (FDA) has approved benzodiazepines for a diverse set of clinical indications, including anxiety, insomnia, seizures, and acute alcohol withdrawal” (Lembke, Papac, and Humphreys (2008, p. 693).

To appreciate the gravity of this challenging concern requires considering psychometric use of psychological terms. Psychometric tests are designed to show someone’s personality, mental ability, opinions and such like. One such important distinction is between ‘traits’ and ‘states’. ‘Traits’ refer to “broad and stable dispositions” regarded in two ways: as “either ‘physical properties’, such as visual acuity, strength, agility, etc. or ‘psychological properties’, such as ‘intelligence’ and ‘rationality’”. ‘States’, in contrast, are regarded as temporary qualities characterised by changeable moods, and is by definition, understandably quite broad. For example, when a person who may start the day feeling happy, hears terrible news and becomes “sad, or angry and the like” (Ackerman & Beier, 2006, p. 147). Pertinently, what constitutes a ‘state’ includes anything that induces or disrupts one’s mood, and that includes anything that causes stress or trauma, not least, a disruption caused by the administration of some causal agent, like psychiatric drugs. During consultation if the clinician fails to distinguish ‘trait’ from ‘state’, the likelihood of misdiagnosis increases substantially. Step wise the consequences arising from a mistaken diagnosis, increases the risk of over-diagnosis, and at each step inappropriate treatment being administered to a patient. Because reaction to types of drugs varies among the population clinicians prescribe through a trial and error drug changing regime, hence concomitantly increasing the risk of exacerbating the patient’s existing distress or trauma. This, disconcertingly, is the standard *modus operandi* for psychiatrists.

#### *An Ontological Consideration of the Conditions that give Rise to Mental Disorders*

Statistically, if a higher percentage of individuals treated by psychiatrists employing a drug-centred versus a disease-centred approach to pharmacotherapy, as longitudinal studies suggest, (Davies, 2014; Frances, 2013; Steingard, 2019;

Whitaker, 2015) are worse off than they were prior to being treated by a psychiatrist, then something is wrong with the epistemic assumptions underpinning disability and mental illness and subsequent drug-centred treatments adopted. As such, this raises questions regarding those consumers reported as benefitting from the services of psychiatrists. How is benefit perceived, and what really underlies the success, if that is what it really is, for them? Since irrespective of which class of psychiatric drug is examined the themes are the same, “short term efficacy with increased relapse risk when drugs are stopped, combined with a conceptualization of mental disorders as chronic, leads to recommendations for long-term drug use” (Steingard, 2019, p. 129). Most, if not all, psychiatric drugs are addictive. Mysteriously, unwary practitioners fail to distinguish ‘withdrawal symptoms’ and can instead misconstrue those symptoms describing them in terms of ‘relapse’ which indeed is quite a common mistake or denial (Breggin, 2013, p. 14-16). Antipsychotic withdrawal reactions include persisting tardive psychosis, emotional lability, instability, abnormal movements, and cognitive dysfunction, symptomatically relative to the type of drug and administration duration in one’s system (Breggin, 2013 pp. 124-125). In practice this amounts to an integrity concern since the harm perpetrated should carry an onus of responsibility by an accountable diagnostician. Addictive drug diminishment or discontinuation of drug through tapering requires a slow attenuation process over a long period, and in order to minimise potential harm the duration of each reduction-step needs close monitoring and attention. Drug tapering requires appropriate medical supervision to monitor the patient’s health and metabolic resolve. What can be identified is that lax governance and poor regulation necessitated to address the enormous management problem of clinicians underreporting adverse-effects/events, omissions dismissively occurring on a global scale (Robertson, & Newby, 2013) adds support for the need to reform and to arrest the ill-conceived practice. By no means unique to Australia, the Pharmaceutical Society of Australia (PSA) released their report in January 2019 titled *PSA Medicine Safety: Take Care*, which specified the scope of harms in Australia resulting from medicine use. “The report reveals that 250,000 Australians are hospitalised each year, with another 400,000 presenting to emergency departments, as a result of medication errors, inappropriate use, misadventure and interactions”. Half of these were preventable. “...the report calculates the annual cost of medication-related problems in Australia at nearly \$1.4 billion – equivalent to 15 per cent of total PBS expenditure” (PSA, 2019).

In fact, these concerns extend beyond psychiatry, exposing significant theoretical and clinical practice deficiencies surrounding medicine, generally speaking, but rendered particularly more onerous for psychiatry because their authority to enforce the Mental Health Act and to coerce patient compliance to advised treatment is regularly occurring irrespective of the harm perpetrated upon patients/consumers. This indicates a common perceptual failing committed by clinicians, a kind of cognitive dissonance manifesting as a failure to recognise, understand, and to act clinically responsibly and appropriately. This is sufficient reason to seek regulatory reform of psychiatry to ensure greater oversight and overall clinician accountability for ill-conceived and dangerous clinical practices.

This may require re-evaluating current education practices to include extended pharmacological training along with appropriate critical and reflective thinking education as essential to psychiatry certification and registration. Currently, psychiatrists can force treatment on two grounds:

- 1) a person has a ‘mental disorder’ which warrants treatment;
- 2) the person needs treatment in the interest of his/her safety or for the protection of others.

As analysed by George Szukler in *Men in White Coats: Treatment Under Coercion*, these two grounds are in and of themselves rather slippery notions classified under ‘Detention and Treatment – the ‘Risk-criterion’ and the ‘Mental-disorder-criterion’ (2018, p. xvii). Psychiatrists are afforded an all imposing authority, operating too often with absolute impunity, in effect subjugating the individual into coerced compliance which essentially strips away the individual’s humanity. The relationship between psychiatrist and consumer/client, even when using the term patient, is authoritarian and is rendered so from an antiquated paternalistic model that treats the individual as a subject for treatment disregarding ones humanity, autonomy and dignity.

Psychiatric drugs are psychoactive agents and they function to alter normal mental functions, despite the paucity of attention given to this fact. It is implausible to believe that these effects “have no impact on the thoughts and behaviours that constitute the criteria for mental-disorders” (Moncrieff, 2019, p.105). In reference to the highly contentious drug-centred treatment model:

“...instead of prescribing treatments for particular conditions, psychiatrists should see themselves as offering drugs which produce drug-induced states which people may or may not find helpful. In order to do this conscientiously, prescribers need to have comprehensive information about the sort of state that different drugs induce as well as the full consequences of taking them over short and longer periods” (Moncrieff, 2019, p. 105).

Psychiatrist Joanna Moncrieff explains that research on psychiatric drugs is limited to the focus on the disease-centred model. There is a dearth of information regarding both the scope of effects from these drugs and the range of iatrogenic harm produced by their continued ingestion. Little is known about “what it feels like to take them; physiological and biochemical research has focused on their effects on presumed disease mechanisms, such as dopamine or serotonin receptor levels, and ignored the many other effects that drugs have” (Moncrieff, 2019, p. 105). Recently, some attention can be identified in certain sectors providing discussion forums to include information from people with lived experience, but this is nonetheless a slow progress and requires an attitudinal shift of gigantic proportions. Convergent research is seemingly ignored by what cognitive scientists call ‘earned dogmatism’ referring to those with assumed expertise who think they have earned the right to ignore other perspectives. A

case in point, Pharmacogenetics, provides valuable information about an individual's capacity to effectively metabolise drugs administered to them:

Cytochrome P450 enzymes are essential for the metabolism of many medications. Although this class has more than 50 enzymes, six of them metabolize 90 percent of drugs, with the two most significant enzymes being CYP3A4 and CYP2D6. Genetic variability (polymorphism) in these enzymes may influence a patient's response to commonly prescribed drug classes, including beta blockers and antidepressants. Cytochrome P450 enzymes can be inhibited or induced by drugs, resulting in clinically significant drug-drug interactions that can cause unanticipated adverse reactions or therapeutic failures. Interactions with warfarin, antidepressants, antiepileptic drugs, and statins often involve the cytochrome P450 enzymes (Lynch & Price, 2007, p. 391).

Many psychiatrists, as evidenced in terms of diagnostic-inflation, polypharmacy and other identified inappropriate medication concerns, are either unaware or simply ignore this biophysical understanding. Indeed, yet many it appears, seemingly persist with their own entrenched drug-treatment options. Simple non-invasive genetic tests can be easily conducted to not only establish a patient's capacity to metabolise a prescribed drug, serving to recognise drug-to-patient compatibility, but additionally to minimise unintended drug adverse harm, whilst mitigating costly existing trial and error drug changing debilitating practices.

This next section extends further into the ontology of mental illness to explore identifiable reasons for misinterpretation and consequent misdiagnosis problems. This will involve examining the sorts of conditions that arise from psychosocial stressors that may lead to the manifestation of psychosomatic symptoms for one class of mental disorders as distinguished from assumed endogenous conditions expressed when triggered by relative factors.

### *Mental Illness: Mind and Matter of Concern*

The foundational ideas underpinning what constitutes mental illness have a long history across diverse fields of enquiry. Whilst characteristically relative to poor mental health, mental illness is, let us bear in mind, also an ever increasing and very profitable phenomena driven by a mental health industry operating in tandem with the pharmaceutical industry. To examine what and how mental illness generally is understood I adopt a philosophical model of investigation by focusing on the epistemic foundations and ontological nature of mental illness. Some definitions are required to contextualise the following methodological reasoning. Epistemology is the branch of philosophy dealing with knowledge. Typical questions are about what knowledge is, what types there are, how it is acquired, specific methods of enquiry, including recognising limits to knowing. Usually this study involves concepts such as truth, validity, justification, verification, and reliability, among other ideas. Every field of human enquiry has an epistemic foundation. The term 'science' is derived from Latin '*scientia*',

which translates the Greek ‘*episteme*’, into the English rendition of ‘epistemology’. Epistemic notions invariably are directed towards or represent something. “Words refer to something; perception (*aesthesis* in Greek) involves perceptibles; knowledge requires a known. In this respect, epistemology cannot be investigated without regard to what there is” (Silverman, 2014). This leads us into Metaphysics, which is the branch of philosophy that studies being *qua* being. Aristotle, one of the earliest theorists, on examining being indicated that we understand the way anything that *is* by how it ‘can be said of another’ or be ‘present in another’ or ‘thought to be of another’ (Studtmann, 2008). Thus indicating there are several ways of being which additionally enabled Aristotle to produce a classification system, referred to as ‘ontology’; “the English suffix ‘-ology’ signifying ‘study of’: e.g., biology is the study of living things” (Silverman, 2014).

Mental illness is conceptualised in a variety of ways but we can draw upon medicine to consider pertinent terminology to contextualise what gives rise to mental illness. Hence, the term ‘etiology’ refers to the source of something, medical or not, the origination. The associated term ‘pathology’ has two senses: firstly, by referring to the science of the causes and effects of diseases and secondly, by referring to the branch of medicine that deals with the laboratory examination of samples of body tissue for diagnostic or forensic purposes. ‘Biomarkers’ are the indicators that can be “measured accurately and reproducibly”. Biomarkers serve as “most objective, quantifiable medical signs modern laboratory science allows us to measure reproducibly” (Strimbu and Tavel, 2011 p. 463). When we think about ‘mental illness’, general descriptions refer to a wide range of mental health conditions - disorders that affect your mood, thinking and behaviour. Typically mental illness includes: anxiety disorders, schizophrenia, depression, addictive-behaviours and eating-disorders. These conditions, however, are also highly controversial phenomena on several fronts attracting much disagreement within the health sciences. In any case, poor mental health becomes a mental illness when persistent signs and symptoms cause frequent stress and affect your ability to function. The central procedure employed to detect a disease is called ‘diagnosis’ which involves identifying the nature of an illness or other concern by examining the symptoms to establish what kind of phenomenon (genus/species) is causing the disruption which often involves the second sense of pathology covered above.

For psychiatry two major concerns are manifestly evident: firstly, “though, ‘concerted’ research efforts in the ‘decade of the brain’ and the years that followed have unravelled critical insights on the pathogenesis of psychiatric disorders, clinically translatable biomarkers in psychiatry are yet to be identified” (Venkatasubramanian and Keshavanb, 2016 p. 3). The absence of clinically identifiable biomarkers that would otherwise provide verification or the physical basis for assumed disorders, are fundamental for making valid diagnosis, and; secondly, psychiatry suffers from a lack of sophisticated diagnostic tools specifically effecting the reliability of diagnosis (Davies 2013; Moncrieff, 2008). Far from exhaustive these inherent and serious diagnostic deficiencies in themselves mar psychiatry. Considerable reliance is placed on three aspects for test of diagnosis



when evaluating its validity: ‘content validity’, ‘construct validity’, and ‘criterion-related validity’. Analysis of these three tests reveal fundamental epistemic weaknesses. To identify these weaknesses we first examine how each validity test is constituted. ‘Construct validity’ is a relational concept which refers to the degree to which a construct captures ‘reality’ or ‘nature’. ‘Content validity’ tests whether the way a construct is operationalised, as in the symptoms included in the checklist or ontological category for a particular disorder, is an adequate reflection of the construct as a whole; for example, symptoms listed in DSM-5 for Major Depressive Disorder (MDD)) (Karter and Kamens, 2019 pp. 47-48). ‘Criterion-related validity’ involves ‘prediction’, for example, to test the validity of MDD in the DSM-5 is tested by considering whether the operationalised construct predicts the outcomes as expected to predict in theory/ies. However, there are several theories for depression and several variables involved that give rise to a broad margin of error (Karter and Kamens, 2019, pp. 47-48) as indicated above between endogenous and reactive manifestations of symptoms.

Research indicates that great effort has gone into understanding the many issues regarding validity and reliability of psychiatric diagnosis that need resolving. Recently, scholars and clinicians, collaborated to produce a rich and varied analysis of the central concept of validity culminating in the publication of *Alternative Perspectives on Psychiatric Validation: DSM, ICD, RDoC, and Beyond* (2015). This body of work addresses the ‘crisis of confidence in psychiatric diagnostic concepts’ inviting an appreciation for the complexity associated with the claim that diagnostic criteria, however they may differ, ‘define a valid psychiatric disorder’. Psychiatrists themselves have identified many problems and inconsistencies in the DSM, that indeed a “crisis of confidence has become widespread ... inside the field. The problems with the current diagnostic paradigm, some psychiatrists believe, has become so great that a significant paradigm shift may be required” (Zachar & Jablensky, 2015, p. 9). In this context ‘reliability’ refers to the amount of agreement between independent clinicians who may gather for case analysis concerning the diagnosis of an individual patient. There are serious inherent problems associated with an over-reliance on this procedure that incorporates several forms of biases, pressure from external industry influences, and existing deficiencies and errant practices as already discussed above.

### *Psychosomatic Disorders*

Diseases caused, at least in part, by psycho-emotional factors are referred to as psychosomatic disorders. Psychosomatic disorders occur most often when repeated emotional stress impedes normal function and leads to dysfunction or structural damage in the body’s tissues and organ systems by damagingly triggering the involuntary nervous system and glands. A common example is a headache ordinarily associated with a common cold or from muscle tension in reaction to stress. When associated with a common cold, as the infection subsides, the headache usually disappears. But headaches arising from continued emotional stress may be self-perpetuated. Not uncommon! A person experiencing muscle tension in the neck, shoulders, and back produced by continued worrying will

effectively serve to increase stress. Causes of psychosomatic disorders have their roots in thought processes, but the physical manifestation of symptoms are real, can be serious, and even life threatening. Though there is some interest in psychosomatic medicine a paucity of understanding and research still remains to be undertaken and this failing generates additional problems. James, J. Strain (2017) from the Icahn School of Medicine at Mount Sinai in his report, *Globalization of Psychosomatic Medicine*, cautions that:

Ubiquitous medical and psychiatric comorbidities demand that not just specialists but all doctors in the world understand the interactions of medical and psychiatric drugs whether they be pharmacodynamic or pharmacokinetic. In a survey of 100 patients seen on a consultation-liaison service, Adson et al. found that the mean number of medications prescribed per patient was 8.8. Eighty-seven were taking drugs that were CYP450 enzyme inhibitors, and 14 were on substrates vulnerable to elevated serum levels from co-prescribed CYP450 inhibiting drugs. In another study 70% were receiving a drug that can alter the function of two major metabolic enzymes – 3A4 and 2D6 thus potentially causing clinically relevant drug–drug interactions. Such studies demonstrate the need to disseminate this information to all physicians because of its impact on the well-being of patients worldwide. Entire countries and even continents are bereft of organized systems to promote psychosomatic and the psychological care of the medically ill information.

On further analysis “... somatic symptom disorders (having pronounced somatic symptoms without objective somatic signs) [occurring] in childhood and adolescence [reportedly] have experienced traumatic events, such as physical or sexual abuse, major loss, natural disasters or have been witnesses to violence. Recent studies are focusing attention on the role of attachment and post-traumatic symptomatology for a better evaluation of this disorder” (Makieieva, N., Penkov, A., Marabyan, R., Kholodova, M., Vasheva, I., 2014).

Similarly, Andrzej Brodziak (2015) appraises the situation from the point of view of the psychosomatic paradigm, indicating that:

...the psychopathologic and social factors are essential to the development, prevention, and treatment of most diseases and clinical situations, the cursory overview of the articles most downloaded from websites of the two top mainstream medical journals (The New England Journal of Medicine and The Lancet) suggests that these substances do not attract much attention for authors and readers of these journals. This should prompt an accurate analysis of “characteristics and trends” of many medical journals regarding the appreciation of a psychosomatic approach.

Though there is a growing awareness of psychosomatic illnesses there remains a gap and need for greater attention and understanding required to improve health services. Psychosomatic or self-induced symptoms have long been the subject of fascination for many within the fields of philosophy of mind, psychology, and meditative schools of thought. On closer scrutiny, integral to this examination is the role of emotion and particularly the role of imagination, or more so, an over-active imagination, at play for the generation of phobias and

other psychosomatic disorders. Recent research within the Neurosciences is making ground towards identifying the neural pathways associated with the imagination. The neurological pathways between a real and imagined experience run in opposite directions but the same brain areas are involved. The brain might use different directional pathways, if that is truly the case, but nonetheless, the main point is that there will be an effect depending on the stressors or stimulus – indeed translatable to psychophysical information received or transmitted.

Throughout history many natural philosophers have pondered the question: does the brain, can the brain, recognise the difference between what it imagines and what it perceives as real? Both are experiences? A physicalist employing a reductive analysis will endeavour to locate the central brain structure responsible for interpreting the combination of information converging from interoceptive, proprioceptive, kinaesthetic, and somatosensory transmissions, from around the body to establish that which determines the difference between real and imagined. Since, if we take into consideration an evolutionary perspective, it is recognised that the ‘stress response’ evolved in humans to enhance the ability to fight, flee or freeze, when confronted with perceived danger as associated with certain types of beliefs. Physiologically requiring the secretion of chemicals including cortisol and adrenalin to stimulate the body, intensifying blood flow towards major muscles to provide strength for defence, for escaping or to freeze (O’Sullivan, 2015). Though an extremely convincing account, pointedly, the same stress response is induced by imagining danger, likewise producing cortisol and adrenalin and intensifying the flow of blood within the body. Whether the danger is real or imagined matters not because the same chemistry ensues. What does this mean in terms of mental health? Your brain does not, in every instance, distinguish between what you imagine or experience as real, and if this exercise of thinking a certain way persists, then that may cause disruption and contribute to deleterious physiological and behavioural effect. Having an overactive imagination can be confusing for some and be particularly challenging during certain developmental stages of life. An over-active imagination can concomitantly be emotionally charged, characteristically manifesting for some, as low self-esteem, lack of confidence, tics and tremors, anxiety, insecurity, and a host of other disruptions.

Determining whether an experience is real or imagined involves a subjective dimension of reality-checking requiring additional areas of the brain and bodily input. At certain developmental stages many will experience precarious times when trying to come to terms with a sense of their own one-self. The brain recognises and responds to information whether imagined or real according to sensory experience, but either way, whether sensory or imagined, it is nonetheless psychophysical information. This information leads to reactive or heightened states triggering physiological processes that alter the body’s normal functioning that, if sustained, can produce unwanted negative effects, phobias and behavioural changes. There is a long history and pertinent philosophical understanding to draw upon. One such example can be traced back to the ancient Stoics’ understanding of fear – they recognised fear can cripple a person in battle (Solomon, 2003). Certainly not dissimilar to contemporary notions of catatonia as a reactive condition triggered by fear, trauma, and a clinically recognised common adverse

effect from psychiatric drugs (Zachar and Jablensky, 2015, p. 8; Kolk, 2014, p. 23-25).

It is not my intention to place all psychiatrists in the same basket especially not those seeking reform. However, adverse effects such as Focal Dystonia, for example, is a condition in which people's muscles go into spasm, can certainly be triggered by trauma and exacerbated by certain psychiatric drugs. From this perspective insight is drawn from psychiatrist, Bessel Van der Kolk's work articulated in *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma* (2014). Kolk laments that too many psychiatrists and clinicians fail to recognise the symptoms of trauma that errantly leads to misdiagnose and mismanaging their patients. Inadvertently perhaps, though in effect, aiding the generation of adverse effects consequently misinterpreted as comorbidities. He is not only pointing to bad clinical management practices but also adding voice to the need and attention given to how psychiatrists are trained and educated. A concern echoed by Allen Frances (2013) who critically suggested that "the right goal for DSM-5 would have been diagnostic restraint and deflation, not a further unwarranted expansion of diagnosis and treatment" (p. xviii). As mentioned above he laments that there are "more deaths from prescribed drugs than from illegal street drugs... When their product are used carelessly the drug companies can be as dangerous as the drug cartels" (2013 p. xv).

Though not exhaustive, in the mix there are other considerations in terms of mind-producing effects and one in particular is the Placebo effect phenomenon. The Placebo effect occurs, as generally recognised, during drug testing trials when patients think they are receiving a new drug, although in many instances they may well be in the group administered a sugar pill. In cases like these it appears that it is a matter of 'mind over medicine', because many people begin to recover from their ailment as though they had received real medicine. It is pertinent to ask what role the imagination plays under these circumstances. But it does not end there because there is another phenomenon which functions in the opposite direction to the placebo effect called the nocebo effect. In this case, a person receives a sugar pill, but deceptively is told that the pill is a new drug that has known adverse effects. Intriguingly, in this scenario, the pill administered is really only a sugar pill which matters not because in these cases the person begins to exhibit those previously described adverse symptoms. Not surprisingly, during any procedure or surgery, standard clinical practice requires that the patient be informed of possible risks associated with the surgery or procedure. Being informed of the risks in many instances can negatively impact one's recovery and this phenomenon is thought to be associated with psychosomatic triggers actuated more often when emanating from a perceived authority. Similarly, much literature has been devoted to the 'Milgram experiment' and other research corollary's regarding perceived authority and consequent reciprocated compliance so I will not rehearse that here because the white-lab-coat phenomenon is well understood in everyday medical practices.

In conclusion I have shown in this essay that psychiatry as a clinical practice suffers operational deficiencies that warrant major concern and necessarily requires

serious consideration to review the authority bestowed upon its practitioners. I have argued that this medical authority is misplaced since psychiatry operates from a fundamentally flawed epistemic framework and for the inherent deficiencies effecting the capacity of its practitioners to effectively and consistently clinically diagnose what indeed constitutes disorders in an ontologically sound way. Currently, psychiatry is a misaligned practice not congruent with what would otherwise constitute medical expertise. Substantiation concerns were highlighted through a review of the practice of diagnosis and the continuing attendant problems, specifically identified were verification, validity, and reliability of diagnosis of so-called psychiatric illnesses. Six main points of concern were identified as ‘over-diagnosis’ or, ‘diagnosis-inflation’, ‘prolonged harm caused by drug induced adverse effects’, as generated by ‘clinical mismanagement’ for too often mistaking ‘state’ for ‘trait’. In an indirect manner it becomes evident that psychiatry’s misplaced authority legitimates ‘harm by coercion’, and this also involves a major concern at the heart of the ethical integrity of the practice. Additionally for referring to ‘adverse effects from psychiatric drugs as comorbidities’ which indeed results in a vicious cycle of polypharmacy, harm on a large scale intensified by under-reporting of adverse effects.

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