NAVIGATING PSYCHIATRIC TRUTH CLAIMS IN COLLABORATIVE PRACTICE: A PROPOSAL FOR RADICAL CRITICAL MENTAL HEALTH AWARENESS

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Mental health awareness campaigns encourage compassionate citizen-to-citizen support and intervention. Rooted in the discipline of psychiatry, mental health awareness campaigns promote psychiatric assumptions without disclosing the longstanding interdisciplinary critique of psychiatry, much of which is articulated by psychiatry itself. The public deserves access to this well-documented controversy since even brief involvement with the mental health system can produce irreversible, lifelong outcomes. Social construction scholarship has contributed to the critique of psychiatry, and thus social constructionist helping professionals may be well positioned to share important critical information in a compassionate and respectful manner. This article draws on the scholarly and professional critique of psychiatry to expose and confront three central psychiatric truth claims disseminated through mental health awareness campaigns. An open-ended series of questions is then offered with the aim of strengthening awareness of critical information currently excluded from public mental health awareness initiatives.

This article brings mental health awareness campaigns into dialogue with the critical psychiatry movement, generating a new approach to awareness referred to here as *radical critical mental health awareness.* The West produces and disseminates mental health awareness initiatives around the globe (Mills, 2014). Public campaigns, such as Bell Canada's Bell Let's Talk (http://letstalk.bell.ca/en/) and the National Council for Behavioral Health's Mental Health First Aid (https://www.mentalhealthfirstaid.org)*,* promote caring, citizen-led intervention, and early detection and treatment of mental illness (Jorm, 2000).

Mental health awareness campaigns present the field of mental health as a unified and cohesive profession, but this is hardly the case (Critical Mental Health Nurses Network, 2015). Just beyond the public eye, decades of critical interdisciplinary

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scholarship document an intensifying critique of psychiatry (Bracken et al., 2012). Much of this critique draws attention to serious misinformation and potential for harm (Burstow, LeFrancois, & Diamond, 2014). The critique of psychiatry has implications for mental health awareness because psychiatry is the disciplinary base of mental health (Rose & Abi-Rached, 2013). Critical movements within psychiatry itself produce some of the most poignant critical analysis of psychiatry (Healy, 2012). Mental health awareness campaigns urging citizens to "get loud for mental health" (Canadian Mental Health Association, 2017) remain silent regarding the "firestorm of controversy" (Cosgrove & Wheeler, 2013, p. 93) that has kept psychiatry in a perpetual crisis of legitimacy since the early 1960s (Foucault, 1961, 1963; Marecek & Gavey, 2013; Rose, 2016). The public deserves full access to key critical concerns.

The 2016 international Galvanizing Family Therapy gathering, celebrated in this special issue, suggests that social constructionist practitioners are well positioned to bolster public awareness of critical perspectives. While mental health organizations throughout the United States were observing their annual national mental health awareness month, practitioners and academics at the Galveston gathering, representing three social constructionist communities of practice, generated practical and constructive critique of mental health assumptions and practices. We strategized together to further depathologize our professions. And we resolved to work harder to better the social, economic, and political conditions of people's lives. The Galveston conversations were characterized by urgency and openness, and I felt thoroughly inspired by the commitment, boldness, and creativity of my colleagues.

Honoring the Galveston meeting in its national mental health awareness context, this article calls for a radical critical strain of mental health awareness, a compassionate practice of information-sharing that respects people' abilities to interrogate psychiatric truth claims and arrive at their own preferred understandings of their experiences, feelings, and needs, whether they seek support within conventional mental health discourses or not. The article begins by acknowledging social constructionist contributions to the critique of psychiatry. It then draws upon the broader critique of psychiatry to expose and confront three powerful truth claims embedded in mental health awareness campaigns. At the article's closing, I offer a brief, open-ended sample of "radical critical" questions that have been useful in my former 20-year counseling practice. Ultimately, I propose that critical—instead of conventional—mental health awareness permits meaningful exposure to a broader range of information and complexity, allowing members of the public to more optimally determine if and how they might engage with the mental health system in times of overwhelming distress and dis-ease.

SOCIAL CONSTRUCTIONIST CRITIQUE

Social constructionist professionals and scholars are familiar with the critical appraisal of psychiatry, having contributed to much of it throughout recent decades

(Strong, Gaete, Sametband, French, & Eeson, 2012). Although many people have found relief and practical assistance through psychiatric mental health services, social constructionist approaches, such as brief solution-focused (de Shazer, 1988), narrative (White & Epston, 1990) and collaborative dialogue (Anderson, 1997), deliberately situate professional practice outside the dominant mental health discourse, bypassing psychiatric assessment and other forms of modernist universalizing wherever possible (Anderson, 1997; Arnkil & Seikkula, 2015; Chang & Nylund, 2013; Combs & Freedman, 2016). Social constructionist practitioners honor each person's own unique priorities, needs, and hopes instead of imposing psychiatric assumptions about normalcy (Sutherland, Sametband, Gaeta Silva, Couture, & Strong, 2013). Social constructionist practitioners are drawn to dialogic partnership, shared inquiry, and mutual responsivity (Anderson, 1997; Chaveste & Molina, 2017; Olson, 2006; Shotter, 2016a; 2016b), collaborative practices that generate rich, multilayered descriptions of people (Paré, 2013). Social constructionist approaches identify and address oppressive contexts and hurtful relational patterns, externalizing problems instead of internalizing, depoliticizing, and privatizing problems through individual disorder diagnosis (Tomm, St. George, Wulff, & Strong, 2014). Social constructionists voice concern regarding the widespread enfeeblement (Chang et al., 2012; Gergen, 1994) accomplished through the commonplace use of pathologizing, psychiatric terms. Harold Goolishian's (2017) writing, shared with Galveston participants shortly before we met together, underlines the need for critical awareness of the mental health industry:

> In the broad field referred to as mental health we have contributed thousands of words over the last century and most of these words are what might be called "deficiency language" in that they create a world of description that understands only through what is wrong, broken, absent, or insufficient. It was our conclusion . . . that this deficiency language has created a world of mental health that can be compared to a black hole out of which there is little hope to escape whether we be clinician, theoretician, or researcher. In using the metaphor of the black hole I am trying to capture the essence of a system of meaning whose forces are so strong that it is impossible to escape out of the system and into other realities. (p. 69)

Social constructionist approaches emphasize the importance of equality, belonging, and social justice for human well-being (Paré, 2013). They provide alternatives to the deficiency orientation in conventional mental health. Attuned to people's partial, in-the-moment wordings of their dilemmas (Shotter, 2016a), social constructionist practitioners come alongside people, inviting their clients' lived experiences, stories, and expertise to collaboratively build upon what is already working in their lives (Chang, 1998, Chang et al., 2012; Chang & Nylund, 2013). The critical awareness articulated in this article specifically invites professionals to assist people as they encounter psychiatric truth claims popularized through mental health awareness campaigns. Practicing radical critical mental health awareness, practitioners can broaden public awareness of key critical knowledges that are currently excluded

from conventional mental health awareness messaging. This article uses the term *mental illness* interchangeably with mental disorder, mental health condition, and psychiatric illness, in keeping with common practice.

TRUTH CLAIM #1: MENTAL ILLNESS IS AN ILLNESS LIKE ANY OTHER ILLNESS

Mental health awareness campaigns disseminate the psychiatric truth claim that human distress and human difference are symptoms of mental illness (Mental Health Commission of Canada, 2010). Mental health awareness programming claims further that "mental illnesses are just like any other illness" (Canadian Mental Health Association, 2017, paragraph 1). Members of the public may not know that phenomena classified as mental illness fundamentally differ from phenomena classified as illness in non-psychiatric medicine.

Psychiatry, a medical specialty, has faced increasing pressure to produce biological evidence of physiological pathology for its ever-expanding catalogue of mental illnesses; tension regarding evidence seems to spike with each *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) revision (Rose & Abi-Rached, 2013). Psychiatric research has generated a vast repository of hypotheses about the biological origins of mental disorder, assuring its scrutineers that scientific evidence of biological pathology would be forthcoming (Healy, 2012; Rose & Abi-Rached, 2013). Indeed, it would be unethical to name, treat, and profit extravagantly from the treatment of pathology that cannot be scientifically demonstrated and confirmed (Burstow, 2015; Healy, 2012, Whitaker & Cosgrove, 2015).

It is therefore no small problem that psychiatry has not yet produced any scientific biomarker evidence of pathology for any of its hundreds of illnesses. Throughout the history of psychiatry, mental illness diagnosis has never been based on objective, measurable evidence of an illness process or physiologic abnormality. Despite a long and expensive search for biomarkers,

> when DSM 5 was published in 2013, there was not a single clinically validated biomarker for any psychiatric disorder (American Psychiatric Association, 2013). . . . [T]here was no clear boundary of ill and well, there were no simple genetic disorders, similar symptomology could arise from different biology, similar biology could lead to different symptomatology (Hyman, 2008, 2010). (Rose, 2016, pp. 95–96)

Critical and conventional academic and practicing psychiatrists align with Rose's (2016) conclusion. Psychiatrist Wayne Goodman's (2009) presentation, posted at the National Institute of Mental Health website, reports, "Despite tremendous progress in basic neuroscience, not a single biomarker has been developed with established clinical use in the management of major mental disorders" (paragraph 3). Goodman (2009) contrasts the absence of biomarker evidence in psychiatry with "the vast array of directly relevant biomarkers" (paragraph 2) in other medical specialties:

For example, the management of diabetes has been aided by the availability of the serum biomarker hemoglobin A1C. In the case of cardiovascular disease, there are biomarkers which confirm a later state event (e.g., cardiac enzymes for myocardial infarction) or help predict disease risk or response to treatment (e.g., lipid profile, C-reactive protein). (Goodman, 2009, paragraph 3)

Former *DSM-IV* chair Allen Frances (2013) similarly acknowledges, "[T]housands of studies on hundreds of putative biological markers have so far come up empty" (p. 11). David Kupfer, chair of the taskforce for the most recent psychiatric diagnostic and statistical manual, *DSM-5* (American Psychiatric Association [APA], 2013), offered the following clarification in an APA press release just prior to the publishing of the new diagnostic manual:

In the future, we hope to be able to identify disorders using biological and genetic markers that provide precise diagnoses that can be delivered with complete reliability and validity. Yet this promise, which we have anticipated since the 1970s, remains disappointingly distant. We've been telling patients for several decades that we are waiting for biomarkers. We're still waiting. (Kupfer, 2013, paragraph 1)

Psychiatry has similarly not been successful in its efforts to develop a single objective laboratory test to detect mental illness. No scan, blood test, scope, biopsy, or scientific procedure involving bodily tissues or fluids is available—nor is any required—for any mental illness diagnosis (Caplan & Cosgrove, 2004; Frances, 2013; Mills, 2014; Whitaker & Cosgrove, 2015. The powerful new tools of molecular biology, imaging, and genetics have not yet led to laboratory tests for any mental disorders (Frances, 2013). Held to a different standard than the rest of medicine, psychiatric classification is superficial (Burstow, 2013; Goodman, 2009; Rose & Abi-Rached, 2013). The absence of biomarker evidence of illness suggests that mental illness is illness *unlike* any other, and is perhaps best not understood as illness at all (Mills, 2014). Criticizing its lack of validity, former National Institute of Mental Health director Thomas Insel (2013) has referred to the *DSM* as "at best, a dictionary, creating a set of labels and defining each" (paragraph 2). Editors-in-chief of three previous *DSM* editions have publically denounced *DSM-5* (Marecek & Gavey, 2013), exposing the chronic absence of scientific evidence that characterized the *DSM* editions they presided over as well (Caplan, 2014).

While the term *critical* may sound negative at first hearing, a critical understanding can extend the range of practical options available to people consulting helping professionals. In my own counseling practice, I found that the critique related to biomarkers was immensely important to the people I met with in my everyday work. Most people held assumptions that mirrored the messages of conventional mental health awareness; they believed their struggles were generally due to mental health problems, presumed genetic, chemical, or neurological pathology, located within their own bodies. I found it important to introduce critical perspectives succinctly and sensitively, using familiar words. When people demonstrated disinterest or

disagreement, I respected the importance of people reaching their own conclusions. Either way, we worked together to address reasons for their distress and generate transformative possibilities. I found that most people I met with experienced critical mental health awareness as something new and utterly liberating, a source of joy, hope, relief, and empowerment.

TRUTH CLAIM # 2: PSYCHIATRIC DIAGNOSIS IS NECESSARY

Mental health awareness campaigns coach laypersons to think about human distress and difference diagnostically, according to psychiatric illness diagnostic labels listed in *DSM-5* (APA, 2013; DeFehr, 2016; Mental Health Commission of Canada, 2010). Many people find psychiatric diagnosis helpful and validating, and yet we hear also that mental disorder diagnosis causes serious harm (Caplan, 2014; Caplan & Cosgrove, 2004; Delano, 2016). Mental health awareness campaigns do not present any of the in-house controversy surrounding diagnosis, and thus the public may not know that mental health professionals are not in agreement regarding the need for diagnosis (Bracken et al., 2012; Kinderman, 2014).

Members of the public may also lack awareness of how processes of psychiatric diagnosis unfold. It is possible to acquire multiple mental disorder diagnoses in a single visit (Burstow, 2015). Diagnosis commonly takes place quickly and invisibly within the first minutes of the first appointment (Frances, 2013). Mental disorder diagnosis is permanent and fixed within people's medical records, even though diagnosed persons and the situations they encounter will develop and change over time. Mental health awareness campaigns advertise recovery (Canadian Mental Health Association, 2016). However, after diagnosis, the only options provided through *DSM-5* are relapse and remission (APA, 2013); there is no provision for recovery or cure (APA, 2013). Patients objecting to their diagnoses may obtain a second opinion from a different diagnostician, but a second opinion cannot remove the mental disorder diagnosis assigned by the first, and a second patient-to-diagnostician consultation could produce additional diagnoses, also permanent. There is potential for addition but never subtraction.

Situations such as child custody evaluations (Deutsch & Clyman, 2016), adoption procedures, acquisition of professional licenses, or purchases of life and disability insurance can require disclosure of mental disorder diagnoses, just as mental disorder diagnoses can result in more expensive insurance premiums (Frances, 2013). Adults diagnosed with a mental disorder in their early years may not be able to recall a diagnosis-free or drug-free sense of self (Goffman, 1963; Moncrieff, 2013). Diagnostic deficit labels, carrying an "air of officialdom" (Paré, 2013, p. 230), tend to saturate identities (Chang, 1998), essentializing thin, decontextualized, deficit descriptions of people, constraining growth (Gergen, 1994; Kinderman, 2014; Winslade & Monk, 2007).

Radical critical mental health awareness promotes an expanded awareness of psychiatric diagnosis, its irreversible duration, its various costs, and its potential

for harm. It exposes pharmaceutical industry influence, demystifies diagnostic categories, and cautions citizens regarding the authority of the diagnostician to formally name the lived experiences, feelings, thoughts, and actions of others. Persons already diagnosed can use the critique of diagnosis to reject defamatory professional descriptions about themselves. Those considering a first-time consultation with a diagnosing professional can use their critical awareness to evaluate options.

TRUTH CLAIM #3: THERE ARE EFFECTIVE TREATMENTS

Mental health awareness campaigns proclaim there are effective treatments (Mental Health Commission of Canada, 2010); however, campaigns are unlikely to explain what the effective treatments are, what they do, and what they do not do. Academic and practicing psychiatrist Joanna Moncrieff's (2013) research indicates that although pharmaceutical industries claim that psychiatric drugs treat mental illness, psychiatric drugs in fact contrast with most pharmaceutical medications in the rest of medicine in that they do not deliver a disease-specific action (Moncrieff, 2009, 2013). There is no scientifically valid evidence that psychiatric drugs correct chemical imbalance, arrest or change illness process, or strategically target specific "symptoms" of mental illness processes.

If psychiatric drugs do not strategically target mental illness, what do they do? Psychiatric drugs act on the central nervous system to superimpose a state of intoxication, an altered brain state, which may or may not be noticeable or preferable (Breggin, 2014; Healy, 2012; Moncrieff, 2013). Moncrieff (2013) reminds people that what is referred to commonly as psychiatric medication is, in fact, drugs. Psychiatric drugs are part of humanity's long history of substance use for the purposes of alleviating discomfort or producing sedation, stimulation, or euphoria. Psychiatric drugs are *psychoactive* substances that act on the central nervous system—the brain and the spinal cord—to stimulate or sedate people, producing changes in behavior, consciousness, mood, and perception, along with other physical changes, such as increased heart rate and blood pressure (Moncrieff, 2013). Other psychoactive substances in the same drug category as psychiatric drugs include coffee, alcohol, nicotine, LSD, cocaine, heroin, amphetamines, and cannabis. Regular use of psychiatric drugs over time often produces tolerance, dependence, and addiction, manifest, in part, by withdrawal or discontinuation syndromes which are commonly mistakenly interpreted as signs of relapse (Lambert, 2005; Moncrieff, Cohen, & Porter, 2013). As Moncrieff, Cohen, and Porter (2013) contend, it is now widely acknowledged that all major types of psychiatric drugs produce distinct withdrawal effects. Response to drugs varies from person to person; however, psychiatric drugs produce their typical range of effects in anyone who takes them, whether they meet psychiatric diagnostic criteria or not (Moncrieff, 2013).

The public may not be aware of industry influence on psychiatry's treatments. The term *side effects*, for example, arbitrarily partitions off some drug effects—usually

the most negative ones—from other drug effects, downplaying the seriousness of many adverse drug responses (Healy, 2012; Moncrieff, 2013). Beyond potentially producing various adverse experiences such as extreme thirst, nausea, or double vision (Moncrieff, 2009), psychiatric drug use can cause serious irreversible harm, and even death (Healy, 2012; Moncrieff, 2013; Whitaker, 2010). The critical literature exposing harm is especially focused on antipsychotics, otherwise known as major tranquilizers, neuroleptics, or atypicals (Moncrieff, 2013; Whitaker & Cosgrove, 2015).

Radical critical mental health awareness invites open discussion of what psychiatric drugs are, what they do, and what they do not do. It does not advise people that drugs are good or bad. Rather, it makes critical information available, inviting people to weigh costs and benefits (Moncrieff, 2013). Access to critical perspectives allows people to benefit from critical research outcomes that cannot be found within conventional mental health awareness programs.

PRACTICING RADICAL CRITICAL
MENTAL HEALTH AWARENESS

Critical awareness requires counter-hegemonic, dialogic inquiry, not the rollout of a ready-made program. It requires the hard work of hearing, and it requires what Shotter (2010) called spontaneous, embodied, responding. Each dialogue should emerge according the possibilities and constraints within the living ecology of each conversation. People let us know when they want to discuss a concern further and when they want to move on, and a critical awareness approach respects people's ability to choose what they feel works best for them.

The cornerstone of critical awareness concerns physiological evidence. The following questions are examples that have been useful in my critical awareness work. Are the people I'm meeting with aware of key differences between mental illness and physical illnesses? Have they been led to believe their difficulties are due to chemical, genetic, or neurological deficiencies or pathologies? Are they aware of relevant critical perspectives concerning legitimacy and validity of mental illness assumptions? Are they interested in exploring alternatives to the dominant pathologizing paradigm? Are people able to differentiate between professionals who are granted authority to diagnose and those who do not diagnose? This awareness may allow informed choices regarding diagnosis prior to a first consultation.

Are people aware of the duration of diagnosis, the way diagnostic process commonly unfolds, the limited level of patient consent required for diagnosis? Have we discussed potential for harm? Have they had opportunity to visit relevant diagnostic criteria on the pages within *DSM*? Have we discussed whether it is easy or difficult to meet psychiatric diagnostic criteria in times of personal and social distress?

Are people aware of what psychiatric drugs are, what they do, and what they do not do? Have they discussed tolerance, dependence, withdrawal? What alternatives

to psychiatric drug use have been considered? What is the evidence that benefits of long-term drug use will outweigh costs? What does the critical literature indicate regarding adverse or harmful drug effects?

CONCLUSION

Mental health awareness campaigns—such as Not Myself, Elephant in the Room, and Make Some Noise—produce an available, diagnosis-ready, drug-ready society. We see the mental health posters and slogans in our healthcare waiting rooms, at the local community center, and on university communications announcements, government-sponsored billboards, and public transit. Commissioning a population of citizen-diagnosticians (DeFehr, 2016), mental health awareness ensures ongoing rehearsal of psychiatric assessment and intervention within every domain of community life: Official diagnosis merely completes what mental health awareness begins. Emphasizing effective treatments and recovery, the message of mental health awareness is hopeful, bright, and clear, like the Olympics coming to town. When we look more critically, we see that mental health awareness intensifies the decades-old pattern of psychiatrization consistently used to stifle dissent, difference, distress, and disquiet in colonial, neoliberal, and advanced capitalist societies (Conrad, 1992; Rimke, 2016). While many people experience their mental disorder diagnosis as validating and useful, others passionately object to the psychiatrization of their distress, wishing they could have accessed information that might have prevented them from a mental illness identity and long-term psychiatric drug use (Delano, 2016).

The Galveston gathering, set in the American mental health awareness month of May, reminds us that social constructionist practitioners can, in significant ways, build escape exits from the black hole of deficit language created by mental health discourse (Goolishian, 2017). As citizens bring their diagnosable concerns to practitioners' offices, social constructionist helping professionals can form paths to critical scholarship currently excluded from public mental health awareness campaigns. Helping professionals can compassionately affirm human distress as an action-guiding (Shotter, 2010) human necessity, crucial to human survival. Instead of psychiatrizing, depoliticizing, and privatizing individual human distress through mental health awareness, professionals can respectfully join with others to realize a more informed, liberating, radical, critical alternative.

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