Correspondence

Response to: Does COVID-19 pose a challenge to the diagnoses of anxiety and depression? A psychologist's view

In her recent article, Johnstone (Bulletin, September 2021) writes critically about how we have responded professionally to the effects of the COVID-19 pandemic. While it is easy to agree with some of what she has to say, much of her argument consists of a series of assertions that are neither entirely accurate nor logically connected to each other or to her main contention.

What is the problem?

Johnstone's central claim is that by using psychiatric diagnosis we label things as abnormal that are in fact normal. The opening example of handwashing and cleaning is unfortunate because it is unconvincing – hardly anybody spends 'most of the day' doing it and there is more to the diagnosis of OCD than cleaning: resistance, ritualising, other compulsions and so on. Certainly, the use of florid metaphors about tsunamis and pandemics of mental disorder is unhelpful, and research does show that much unhappiness and anxiety during the pandemic has proved to be transient. But then many illnesses, including those caused by the COVID-19 virus, can be transient and non-disabling – it doesn't mean they aren't illnesses. Every doctor, including every psychiatrist, knows the value of watchful waiting: the question is how we respond when symptoms are not transient or non-disabling. When Johnstone talks about 'people with a psychiatric history', I take it to mean people who most psychiatrists would regard as having a long-term mental disorder. We can agree that 'It is untrue and even patronising to assume that everyone in this group will fail to cope', but does any psychiatrist actually assume that? More fundamentally, Johnstone is opposed to the idea of psychiatric diagnosis (and not just of anxiety and depression) because it rests upon defining mental illness in relation to social norms while (as she and her colleagues have argued elsewhere) masquerading as being analogous to the more legitimate processes of medical diagnosis. It is an error to assume that medical diagnosis is radically different in all respects: it does for example recognise social causes (cigarette smoking, hazardous drinking, unhealthy eating, physical inactivity) and defines some of its most prevalent disorders such as hypertension, hyperlipidaemia and diabetes mellitus according to deviation from norms. More important is the question of whether the states so diagnosed are harmful and, if so, whether intervening is beneficial.

Who is responsible?

I found it difficult to suppress a smile at Johnstone's jibe about the self-serving nature of articles promoting the importance of research in the areas of expertise of the authors. But it is too narrow to name only academics and Public Health England as the actors in a debate about the nature of public mental health – professional bodies, the pharmaceutical industry, politicians and journalists are among others who set the agenda and the tone. The emergence of the phrase 'mental health' is an interesting topic in its own right, and one way to view its effects is to see it as a vehicle for medicalisation of distress. It might, however, be as useful to think of it as effect rather than cause of the individualisation of societal problems – a phenomenon that has deep cultural roots and consequences that go beyond psychiatry into penal policy, welfare provision and education.

What are the alternatives?

It is a category error to propose formulation as an alternative to diagnosis – the latter is a descriptive statement, whereas the former provides an explanatory framework, a point illustrated by the training requirement that psychiatrists are expected to be able to make a biopsychosocial formulation and management plan as well as coming to a diagnosis. It is not news that the onset of many mental disorders is preceded by adverse life events and difficulties – research in this area goes back half a century – or that the content of some people's illnesses reflects these experiences. However, bundling together all mental disorders as 'various forms of distress. . .that are understandable responses to adversities' does not do justice to the issues. Not everybody reports life adversities before onset; the nature of adversity may be reflected in the content of some but not all conditions; life adversity does not explain the differences in form of the various mental disorders; there is a strong genetic risk for some disorders. It is difficult to know what it means to say that mental disorder is 'what we do' in response to threats, but in my reading it is hard to see it as other than dismissive of the reality of mental illness.

Collective trauma and a collective response

There is a disconcerting *volte face* at the end of Johnstone's piece. Having presented the argument that what we are seeing in the pandemic is essentially normal, part of a meaningful response to stress and not to be pathologised, we are finally offered the idea of collective trauma – defined as an experience that overwhelms our usual ways of coping. If states like anxiety and depression are to be thought of as arising because of this overwhelming of usual ways of coping, how is that different from the way that psychiatrists think about what they are likely to call mental disorders? Only, it seems, in the reluctance to use a descriptive vocabulary that distinguishes between different conditions – as if it is a trivial matter whether somebody is hearing voices, embarked upon life-threatening self-starvation or unable to touch a newspaper for fear it will give them a fatal infection. How are we supposed to use this way of thinking to help people now, while they and we wait for a fairer society? Local peer networks may indeed help some, but they won't suffice for the severity and diversity of problems we face. One of the central tensions of healthcare is that we can recognise that health and illness have social determinants, but as clinicians it is individuals that we see. It isn't a question of

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picking one or the other – both are important, and I think most psychiatrists understand that.

A conclusion

Surely we can all agree about some things: it is important not to medicalise distress that does not merit such an approach; social adversities are important risks to our mental well-being, and government policies in recent years have both exacerbated these risks and done much damage to society's ability to help those most in need as a result of them; professionals in healthcare have a responsibility to speak out both for individuals in need and also about the social conditions that contribute to their difficulties. These simple and powerful messages are obscured by wrapping them, as here, in a muddled polemic animated as much as anything else by anti-psychiatry sentiment.

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Author's reply

I do indeed agree with the statements in Professor House's final paragraph and with several of his other points, for example, that there are many vested interests in the debate about public mental health, and that we can see the term 'mental health' itself as both effect and cause of the individualisation of societal problems. Indeed, it is that individualisation – not, as he seems to assume, the psychiatric profession itself – that my critique is aimed at. I have always argued that all professions, including my own, need to be aware of the limitations and potential harms of their theories and practices. That is why I raised concerns not just about over prescribing, but about 'formal psychological interventions [which may be] unnecessary for most and can actually be harmful if implemented too early.'

I find Professor House's final phrase '. . .a muddled polemic animated as much as anything else by anti-psychiatry sentiment' the most worrying part of his response. This kind of language suggests that he has moved beyond rational and evidence-based argument, into *ad hominem* dismissal. It invites a fight rather than a debate, and since I do not identify as 'anti-psychiatry' (whatever that means) I have no desire to take up such a challenge. I will simply observe that the areas in which I take a different position from him are fundamental, legitimate and increasingly common. For example, clinical psychologists' professional guidelines on formulation state that it is 'not premised on a functional psychiatric diagnosis'.[1] Professor House is free to use the term differently but not to simply rule other definitions out of court. Yes, we need to offer immediate help to individuals as well as addressing adversities, but that help does not have to be based on unproven medical assumptions about the nature and origins of their distress. Yes, there are social causal factors and unclear boundaries in some physical health conditions, but no one is arguing that diabetes is a mental health problem; common sense tells us that this analogy doesn't work, despite the claims of anti-stigma campaigns and some professionals. And so on.

In 2017, a United Nations report noted 'The urgent need to. . .target social determinants and abandon the predominant medical model that seeks to cure individuals by targeting "disorders"' and recommended that 'Mental health policies should address the "power imbalance" rather than "chemical imbalance"'.[2] Rather than allowing ourselves to be distracted by attempts to defend a failed paradigm, we all urgently need to work towards this future.

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Declaration of interest

L.J. is an independent trainer and offers training in formulation and the Power Threat Meaning Framework (PTMF). She has published books and articles on formulation and is one of the lead authors of the PTMF.

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Lack of respect and balance

This editorial and current issue of BJPsych Bulletin do nothing to be 'respectful and balanced' about issues of trans health. Reprinting the article which caused the controversy in the first place means that it is exposed to a wider audience, and instead of having a counterbalancing view in another article, it has the article by Griffin et al which contains a number of anti-trans talking points. Anything which is supportive of trans people or current best practice standards for trans health is relegated to the letter pages. None of the authors of the two articles are gender identity specialists; they have instead mobilised their credentials in other areas to claim expertise in an area where they have none. The voices of trans people are either absent or denigrated as some kind of online-based groupthink.

Trans health is its own research field, and there are plenty of researchers that the *Bulletin* could have reached out to for a counterbalancing view. Instead, they have amplified anti-trans

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