



# Psychosis

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## The medical model in mental health: an explanation and evaluation

by Ahmed Samei Huda, Oxford, Oxford University Press, 2019, 398 pp., £32.99 (paperback), ISBN 978-0-19-880725-4

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## BOOK REVIEW

**The medical model in mental health: an explanation and evaluation**, by Ahmed Samei Huda, Oxford, Oxford University Press, 2019, 398 pp., £32.99 (paperback), ISBN 978-0-19-880725-4

In 2008 the National Institute for health and Care Excellence (NICE) published its guidelines on Attention Deficit Hyperactivity Disorder (ADHD). I had been on a “panel of experts” and was appointed as the lead reviewer of the final guideline. I had a sense of déjà vu reading Dr Huda’s book on the medical model in mental health. The NICE guideline group included a specific remit to examine the validity of ADHD as a diagnosis. They approached the task in an apparently transparent and methodical manner, setting out the criteria by which they would assess validity. My fear that having a critic involved would allow the tokenistic claim that in developing the guideline they had covered the full range of opinions was borne out. My input fell on deaf ears. Although they stated the reason for examining the validity of the diagnosis of ADHD was that it had been the subject of considerable controversy, there were no references drawn from authors who are critical of the concept, and issues such as the cross-cultural validity, gender disparity, and social class distribution were largely ignored. Yet despite this, by its own standards, the guideline provided little evidence that ADHD satisfied the validity criteria they specified (Moncrieff & Timimi, 2012). All their hundreds of pages of analysis ended up with the glib conclusion that “ADHD is a valid diagnosis”. Of course, it did. This is what “scientism” looks like; lots of science sounding language, percentages, and numbers. By looking like they do science, they bypass the human problems of bias, cognitive dissonance, guild interests, and concern about professional reputation.

Dr Huda likewise carefully sets out his methodology for illustrating why the medical model works best in mental health by essentially drawing comparisons with other branches of healthcare in order to convince the reader that the rest of medicine is just as imperfect as psychiatry. But this requires philosophical contortions that, to most non-psychiatric doctors, look unsustainable. He concedes that we are unable to demonstrate the processes of “normal” mental functions of the brain and that we may therefore be unable to demonstrate “abnormal” mental functions. This means he must argue throughout the rest of the book that knowing nothing about the pathophysiology of mental health conditions doesn’t cause any more issues for psychiatric technology than the rest of medicine. Yet nearly all the examples from general medicine he compares psychiatric “disorders” to are conditions of known pathology.

Thus, he compares psychiatric diagnosis to tuberculosis as “*an example of diagnosis with clinical benefits (‘utility’) ... before the discovery of adequate scientific knowledge explaining the cause of the diagnosis (‘validity’)*”. It doesn’t need rocket science here to see that “depression” and “tuberculosis” are on different terrains.

Diagnosis is a system of classification based on the cause. It is the process of determining which disease or condition provides the proximal explanation for a person’s symptoms and/or signs. This enables matching of specific treatments to address specific pathological processes. Pseudo-diagnoses, like say “bipolar disorder”, cannot explain behaviours as there are only symptoms that are descriptions (not explanations) of behaviours or experiences. Even using the word “symptom” may be problematic as in medicine symptoms usually refers to patients’ suffering/experience as a result of an underlying disease process and is therefore associated in our minds with a medical procedure leading to an explanation for the symptom. Different classification systems serve different functions. A diagnostic classification is a classification by explanation. That’s why we say “*My doctor said that the cause of my chest pain was acid reflux, not a heart attack*”. But psychiatric diagnoses do

not explain symptoms. If I were to ask the question “*what is depression?*”, it’s not possible for me to answer that question by reference to a particular known pathological abnormality. I will have to provide a description such as “*depression is the presence of the low mood, negative thinking*” and so on. A description cannot explain itself. Using depression to explain low mood is like saying the pain in my head is caused by a headache. Whilst the rest of medicine has plenty of issues, diagnostic boundary disputes, over-treatment, conflicts of interest, etc., the reason there is no anti or critical cardiology movement is there is no dispute about the parameters of the conditions. Blood pressure is a measurement in external (to the diagnosers' beliefs) reality. Kidneys don’t worry about paying the bills, seek meanings for their suffering, or harbour dreams about their future. In mental health practice, nothing can escape interpretation and subjectivity.

All the rest of the book is then a house of cards, each chapter collapsing with the lack of attention to, or understanding of this central issue. A century of research has produced nothing in terms of understanding the pathophysiology. Then of course, there is the inevitable selective use of references. The large available literature that shows how the outcomes from treatment have got worse the more psychiatric medications and other treatments we use are circumvented, with the arrogant decision to ignore any non-doctor author, but avoiding some of the most incisive criticism from doctors such as Professor Peter Gøtzsche, one of the co-founders of the Cochrane collaboration, whose prolific research has included devastating critiques of the evidence on psychiatric drug treatments (see for example, his latest book, 2020).

This stuff will no longer wash. Whether it takes 5 or 50 years, the medical model in mental health is an unsustainable busted flush. If authors like Huda keep trying to convince themselves that psychiatry is no different from the rest of medicine, then they risk ending psychiatry as a profession. This would be a terrible shame. Psychiatry’s strength comes from the fact that it is different from the rest of medicine and involves an engagement with nature of the human condition, suffering, and its wide roots in social, political, and cultural meanings and realities. This is what the rest of medicine needs help with and why psychiatry’s difference to the rest of medicine should be seen as valuable quality, not an embarrassment.

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