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PROMOTING EMOTIONAL HEALTH AND CLEAR THINKING

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Where's the madness?

CLINICAL psychologist Professor John Read has spent over 40 years highlighting the dangers of many psychiatric treatments, and the still largely overlooked role of adverse life events in causing mental health problems. We interview him in this issue, including about his recently published analysis of several thousand media reports of coroners' inquests in England and Wales, where suicides and concomitant antidepressant use were mentioned.

He was careful in the conclusions he drew but they are still extremely powerful: "We do not know in how many cases the problems for which the drugs were prescribed contributed to the deaths. Nor can we tell in how many of the 7,829 cases antidepressants actively contributed to the deaths. We can say, however, that antidepressants failed to lift the depression sufficiently to prevent 2,718 hangings, 2,329 overdoses, 440 cases of jumping or falling to one's death, 126 cases of shooting oneself, and 40 of setting oneself on fire. In none of the 3,543 cases for which the coroner reached a clear 'suicide' verdict can antidepressants be reasonably described as effective. In somewhere between 40 per cent and 80 per cent of the overdoses, the medicines prescribed to help prevent suicide were used to commit suicide."[1]

The findings were reported in at least two national newspapers, which led Dr Adrian James, president of the Royal College of Psychiatrists, to write to the papers, saying, "I was disappointed to read your article, which has potential to unjustifiably worry readers who are taking antidepressant medication or know someone who is. The study cited in your article found some individuals who died by suicide were taking antidepressants at the time. This is mere association. It does not demonstrate a causal link. It is a fundamental principle of science that correlation does not equate to causation. To suggest otherwise is simply wrong."

There was more, but the above led psychiatrist David Healy, founder of RxISK, an independent drug safety website, to respond to Dr James, "Your press release risks harming patients and their families more than the article you criticise.

"The authors of the paper ... took care to get the wording right. They note that, in the case of suicides in people taking antidepressants, the antidepressants were clearly not working. They do not say they caused the suicide."[1]

He goes on to say that, at inquests, doctors do not claim an antidepressant caused a suicide primarily because the doctors are advised by defence unions not to blame the drug. (Off the record, lawyers for medical defence unions have conceded this, he says elsewhere.[3]) "This is a business matter. Rather than support a doctor to help a family at a time of great distress, and support him to advance public safety, defence unions seek to avoid further costs."[2]

Healy has himself written about an inquest where he was called as an expert witness, and the GP was advised by his defence union not to talk to him, remaining silent at the inquest.[3] A mentally healthy 25-year-old man had asked the GP to prescribe citalopram because he was nervous about some forthcoming professional exams. He was in a steady relationship, had no debt or other problems and was actually expected to do well in his exams, rather than struggle to pass them. A week later he hanged himself. Healy gave evidence that there was a convincing case to implicate the antidepressant, especially as the data showed that it could unequivocally cause suicide.

Peculiarly, in the UK, a coroner cannot implicate a prescription drug in a death but is perfectly free to do so in the case of a street drug. Even so, the coroner was sufficiently troubled to file what is called a Regulation 28 report, raising his concern. Alas, the Medicines' Regulator replied that, as the doctor had not himself implicated the drug, the regulator could do nothing.

And so it goes on, round and round, staying schtum, hands tied... Alas, there is still much work left for critics of traditional psychiatry to do, and some pay a high price for doing it. Loren Mosher, first chief of schizophrenia studies at the National Institute of Mental Health (NIMH), who became critical of psychiatry's relationship with the pharmaceutical industry and set up the highly successful supportive communities for schizophrenia patients, known as the Soteria Project, ended up fired from his job in 1980. Three years later the project had to close because of withdrawn funding. Much more recently, Danish doctor Peter Gøtzsche co-founder of the Cochrane Collaboration (an international collaboration to evaluate medical research free from the heavy hand of drug company influence) and leader of the university-affiliated Nordic Cochrane Centre, found himself fired too, after he became increasingly outspoken about the dangers of antipsychotics.[4]

Professor Read, who is equally brave and outspoken, commented during our interview, "They have punished Gøtzsche but they haven't got rid of him by any means. He is undefeatable." We need to be grateful to the indefatigable critical psychiatrists, psychologists and others, who put their careers on the line in what, as Read terms it, is a struggle for human rights.[5] ■

The Editors

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CONVERSATIONS

__John Read__ tells __Denise Winn__ about his work showing adverse life events explain most types of emotional distress, and how the medical model ignores it.

Lack of insight: the story of psychiatry

WINN: John, you have an enormously impressive track record as a clinical psychologist, both in the UK and New Zealand. Your research has been cited by other researchers thousands of times and you have written 49 book chapters and five books, along with 200-plus papers. All this time, you have been a fierce critic of the medical model of psychiatry and the failure to look at mental health problems in terms of what is going on in people's lives. What brought you to that way of thinking?

READ: I think I started off with the same assumption as most members of the public, according to surveys, which is that mental health problems are caused by bad things happening. Some get persuaded to abandon that viewpoint, especially if they come into contact with psychiatrists who push a different model. But, for most of us, it is just so obvious that depressing things may lead to depression; frightening things to anxiety; and really strange nasty stuff to psychosis.

That thinking got reinforced in my very first job as a nursing attendant in New York, in the 1970s, in a psychiatric hospital which was actually relatively progressive in that they didn't medicate any patients for the first two days – I didn't know how radical that was at the time. Because I was a lowly nursing attendant and safe to talk to, and a reasonably good listener, people would tell me striking things about what was going on in their lives or had previously gone on in their lives. I thought that was interesting in terms of understanding what had got them to the point where they were suicidal or hearing voices, and so on. Yet none of that was of any interest to the psychiatrists or most of the other professionals, who were all busy working out what diagnosis to apply, so that they knew what pill to administer.

Many people have come to believe in the chemical imbalance story sold very effectively by the drug companies and psychiatry – which is unfortunately dependent on drug companies and has forgotten what the proper boundary is between a professional body and a profit-making body.

WINN: I read an interview with you on the Mad in America website where you described understanding psychosis as something similar to dreams, just experienced when awake – which is exactly the HG understanding about dreaming and psychosis. You wryly observe that, while most people, including professionals, accept dreams have some meaning, similar experiences when awake are dismissed, by psychiatrists at least, as meaning nothing – just a fault in the dopamine system, rather than reflecting something in our life experiences or circumstances.[1]

You were, I believe, one of the earliest researchers to find the connection between childhood abuse and psychosis?

READ: Yes, my first review was in 1997. Obviously people had written about the idea and lots of service users knew about it, but mine was the first academic review.

WINN: One of your research interests is in how people with what are usually termed hallucinations and delusions understand those experiences themselves. Broadly, what have you found?

READ: I'll start with the surveys and come back to my own experiences. Surveys of people with a diagnosis of, say, schizophrenia, show an even stronger psychosocial perspective than the average member of the public. One large study found that 90–95 per cent of people with a diagnosis do not believe, at least at the beginning of their treatment, that there is anything biologically wrong with them. This, unfortunately is mispresented by psychiatrists as a lack of insight which, miraculously, becomes a symptom of the illness – ie trying to explain to the psychiatrist that there is nothing biologically wrong with you. This is a very effective power play and double bind – you can't talk your way out of it. And if you get very upset, as a consequence, the more that confirms that you are crazy.

WINN: I thought that lack of insight referred to people thinking hallucinations or delusions they may have are actually real.

READ: That is one form of lack of insight, but, overall, it is a misuse of the term originally used by psychodynamic therapists. They used it to mean that someone wasn't aware of something that had gone on in their life that was still affecting them, because they were repressing it. But psychiatry has co-opted it and one of the meanings now is that the person doesn't have insight into the fact that they are ill – and that they need medication. One of the criteria for psychia-

try's version of lack of insight is being to have medication, which is quite astonishing. Then they turn it into an actual symptom of the illness, which is also strange. They call it anosognosia, which makes it sound like a real medical thing.

WINN: Apparently French neurologist Joseph Babinski created the term in 1914 to describe someone who had lost the ability to use or feel the left side of their body – but clearly it has been widened out to encompass schizophrenia, too.

READ: Surveys show that most people with a diagnosis of schizophrenia think that the voices they hear mean something about what is going on in their lives, but usually they aren't asked about that. I should stress that not all people think this way, and not just in psychosis, because some people find a biological explanation reassuring. And the fact that there is a diagnosis means that others have the same recognisable condition, and therefore the doctor must know what to do, and that can be reassuring, too.

My own experience with patients confirmed the research – if two things happen: first, if you can establish a relationship with someone who is hearing voices and is a bit paranoid; and, second, if you ask directly about what has gone on. This is not as straightforward as it might sound. Establishing the relationship can be difficult because, understandably, if you have been through enough bad stuff with other human beings, you don't trust very easily. And if, on top of that, you have been through bad stuff in the mental health system, you won't easily trust your thirteenth clinical psychologist.

WINN: Are you familiar with Canadian physician Gabor Maté's idea of trauma with a big T and a little t? The big T refers to the kind of things you have just talked about and the little t might be bullying at school or being told you are not good enough. What about the people with the little t experiences who end up with a diagnosis of schizophrenia? They haven't anything very terrible to tell you, but obviously something did happen that affected them.

READ: I think the word trauma has got us into a lot of trouble. I tend to prefer adverse events. It is more inclusive. An event like being raped is awful, but so is being continually emotionally abused every day as a child, and being told you are rubbish and you will never amount to anything. It might not meet the traditional criteria for trauma but can be just as debilitating. That is why I prefer to broaden it out to adverse events.

WINN: Indeed. And I think that people who seek therapy absolutely recognise the impact on them of such negative messages being drummed into their brains from a very early age. However, even when it *is* accepted that circumstances can play a part in mental distress, the medical profession often talks about a predisposition to vulnerability. In other words, they claim, it is genetic. You would say otherwise.

READ: Yes, because it is absolutely a mistake. In the 1970s, the stress vulnerability model was invented. It is in every textbook, taught to every mental health professional, that you inherit a predisposition to various things, and the strength of that predisposition determines how much stress is required to push you over the edge into whatever diagnosis you end up with. What biological psychiatry never tells people, and they have probably forgotten themselves, is that the original model was very clear that the predisposition could be trauma based.[2] The researchers included trauma itself as the predisposition to subsequent traumas and stresses, pushing someone over the cliff. And that is absolutely obvious. If, say, you have been physically abused as a child, you are going to be more sensitive to and more damaged by physical abuse later. So both aspects of the stress vulnerability model can be adversity based – or trauma based, to use the word they did. You don't need a genetic predisposition.

Also, they haven't found these genetic predispositions! They are still at it, after 50 or 60 years, saying, "Please give us another £50 million and we will find it one day". The genetic research has gone nowhere. Researchers have given up looking for specific depression or schizophrenia genes and now they are looking for combinations of hundreds of genes. It is a huge waste of money. I was at a conference with my colleague, Professor Richard Bentall, probably our best clinical psychology researcher, when he asked the geneticists, "Can you identify a single patient who has ever benefited in any way whatsoever from any of your research?" And there was silence.

WINN: Your latest paper, which looks at antidepressants and suicide, starts with some pretty horrific statistics, none of which, unfortunately, are a surprise. For instance, in the UK, in 2021 to 2022, there were 83.4 million prescriptions of antidepressants made out to 8.3 million people, representing a five per cent increase, in both prescriptions and people, from the previous year.[3] This is nearly one in five of the adult population. Similarly high prescription rates are found in Australia, Belgium, Canada, Iceland, Portugal, and Sweden.[4]

John Read *is professor of clinical psychology at the University of East London. He worked for nearly 20 years as a clinical psychologist and manager of mental health services in the UK and the USA, before joining the University of Auckland, New Zealand, in 1994, where he worked until 2013. He was director of the clinical psychology professional graduate programmes at both Auckland and, more recently, the University of Liverpool, and has published over 200 papers in research journals, primarily on the relationship between adverse life events and psychosis.*

He is chair of the International Institute for Psychiatric Drug Withdrawal (www.iipdw.org) and on the board of Hearing Voices Network – England (www.hearing-voices.org). He is also editor of Psychosis, *the scientific journal of the International Society for Psychological and Social Approaches to Psychosis (www.isps.org), and a regular contributor to* Psychology Today *(www.psychologytoday.com/gb/contributors/john-read-phd).*

His books include Models of Madness: psychological, social and biological approaches to psychosis *(2013), edited with Jacqui Dillon and published by Routledge; and* A Straight-Talking Introduction to the Causes of Mental Health Problems *(2022), co-authored with Pete Sanders and published by PCCS Books.*

In the UK, 54 per cent of prescribed antidepressants are SSRIs (selective serotonin reuptake inhibitors), followed by SNRIs (serotonin and norepinephrine reuptake inhibitors), which make up 23 per cent of the prescriptions, and tricyclics, also 23 per cent.[5]

You analysed nearly 8,000 media reports between 2003 and 2020 of coroners' inquests in England and Wales where suicide and antidepressants were mentioned.[6] SSRIs accounted for just under half the antidepressants, and tricyclics just under a quarter. Of 2,329 cases of death by overdose, 933, just over 40 per cent, were overdoses of antidepressants, over half of which did not involve other substances. That is pretty shocking.

READ: All we can say unequivocally about which antidepressant drugs are the most dangerous in an overdose situation is that the two older types, monamine oxidase inhibitors and the tricyclics, were extremely toxic. There was a period, I think in the 1980s, when the leading mechanism for suicide was antidepressants. Part of what I was trying to communicate in the inquest study was that SSRIs, which account for 70–80 per cent of all prescriptions today, were marketed as safer – not that they were more effective, or more superior to placebo than the older drugs, but they were actually marketed as safer in an overdose situation. My paper suggests that might not be the case. However, it is not rigorous research; it is certainly reporting large numbers, but it is not an experiment or a research project, so we needed to be careful with the conclusions we drew.

WINN: If they were marketed as safer, were there any grounds to think they were safer?

READ: Probably the companies marketing these drugs produced the requisite two studies, which is all you need in this country in order to get Mental Health Regulatory Authority approval. And, as a quick aside, how terrifying is it that, at this moment, the Government is putting through a bill to speed up approval of drugs by ruling that, if the Food and Drugs Administration in America has approved one, then we should automatically approve it in the UK. It is terrifying because the FDA is severely influenced by drug companies. But, to answer your question, companies could have produced a couple of studies showing that SSRIs were slightly less dangerous. If the studies were big enough, there would have been some suicide attempts with both the drugs being tested and the comparison drugs. The numbers would have to be huge, so I don't know how they could do that. However, not having any evidence wouldn't have stopped claims being made.

WINN: In an editorial for the *BMJ* in 2015 on serotonin and depression, psychiatrist and psychopharmacologist David Healy really tore into the marketing of SSRIs. He said the marketing pushed tricyclics largely out of the picture and it was a problem because, he said, SSRIs were never shown to work with depression that was associated with a greatly increased risk of suicide.[7] Do you know about that side of things?

READ: I am familiar with David's work and that editorial. And it is even worse than that because the drug companies have since acknowledged that SSRIs themselves increase suicidality in people up to the age of 24. They draw attention to that in a black box suicide warning on their information leaflets. In any other branch of medicine, if you had a drug that increased the thing that it was supposed to be decreasing, it would be off the market the next day. But somehow in the world of psychiatry and mental health, different rules seem to apply.

WINN: That is very much the point that you make in your paper about the coroners' courts: "We do not know in how many cases the problems for which the drugs were prescribed contributed to the deaths. Nor can we tell in how many of the 7,829 cases antidepressants actively contributed to the deaths. We can say, however, that antidepressants failed to lift the depression sufficiently to prevent 2,718 hangings, 2,329 overdoses, 440 cases of jumping or falling to one's death, 126 cases of shooting oneself, and 40 of setting oneself on fire. In none of the 3,543 cases for which the coroner reached a clear 'suicide' verdict, can antidepressants be reasonably described as effective. In somewhere between 40 per cent and 80 per cent of the overdoses, the medicines prescribed to help prevent suicide were used to commit suicide."[6]

You feel that these dreadful figures, behind all of which lie tragic personal stories, *under*-represent the true picture, partly because National Institute for Health and Care Excellence (NICE) guidelines for media reporting of suicides state that best practice includes avoiding presenting detail on methods.

READ: The paper relied entirely on one bereaved father, who wished to remain anonymous, who gathered as many media reports as he could find over that period of time, which was a remarkable effort on his part. But a lot of suicides don't reach inquests and he may not have found all the reports including antidepressants. So, although it is not a small picture, still, there is no way to know how many we have missed.

WINN: You say in the paper that, since 2009, coroners in England and Wales have had to report cases where it may be possible to prevent future deaths. Presumably they do and I wonder if you know what happens.

READ: My guess is not enough and it certainly hasn't been acted on. It would be sad if there were no national monitoring because, otherwise, what would be the point of all these inquests. The parallel for that is what happens in mental health services when there is a suicide. We published a paper based on Freedom of Information requests

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sent to all mental health trusts in England, asking about rates of suicide of people in their care and how many people who had killed themselves had been offered treatments for depression recommended by NICE, such as psychological therapy.[8]

Every time anyone kills themselves in the mental health services, there is a huge enquiry, so we assumed naively that the trusts would have all this data. Nearly half provided no information at all. Just over half provided suicide rates only, producing a mean annual suicide rate per trust of 20. Only one trust was able to access and report data about who was offered which therapies in the year leading up to the suicides. It seems extremely problematic that most mental health services do not have ready access to the data on the factors that might have contributed to suicides within their services. I was staggered.

> *"In any other branch of medicine, if you had a drug that increased the thing it was supposed to be decreasing, it would be off the market."*

WINN: NICE has known of a "small but significant increase" in suicidal thoughts in the early stages of antidepressant treatment since 2014, you tell us, and, indeed, they advised monitoring in early stages. But this doesn't always happen, as we know. I wrote in this journal about a harrowing case concerning a young man of 22 who, at an urgent mental health assessment, told the community psychiatric nurse that he was deeply depressed, thought of suicide every day, specifically mentioned hanging and revealed an extremely serious suicide attempt two years earlier, when he took an overdose, slashed his wrists and stabbed himself in the heart. A psychiatrist prescribed an SSRI without even going in to see him and no follow-up appointment was made. He hanged himself three weeks later.[9]

Now NICE has amended its guideline to make it clear that people should be checked one week after starting antidepressants. Before, it said 'after one week', which could presumably have been interpreted as any time after a week, or they wouldn't have bothered to change it.

In your conclusion to the paper, you pull no punches: "It has to be said, on behalf of the thousands of people whose deaths provide the basis for this article, that doctors and professional bodies have an ethical responsibility to avoid prescribing or recommending treatments that are no more effective than a placebo for most patients, which increase suicidality in many, and which constitute an effective method for killing oneself."[6] You probably think, then, that antidepressants shouldn't be prescribed at all? Is that the outcome you would hope for?

READ: Let me just clarify my position. I don't think we should not have antidepressants. My position on everything except ECT, and we'll put that on one side, is that we need to enforce the ethical principle of informed consent. So it is not for me, or you, or anyone else, in my view, to say what treatments should be on offer but all of us involved in mental health should insist that there are choices and that patients are fully informed. So if people are told that there is an increased risk that they might commit suicide, that they might experience withdrawal effects on stopping, which in half of people are likely to be severe, that there is only a very tiny percentage of people for whom antidepressants are better than placebo, and all the rest of it, and they still choose to take the drug, that is their right, I believe. So I am not against them and there is no question that antidepressants help some people, certainly in the short term. The fact that that is almost always because of the placebo effect doesn't, at one level, matter.

WINN: Final question. I was impressed to read about the impact your research has had on academics and professionals in the field. This includes international uptake of your clinical workshops; invitations to numerous international conferences, often as a keynote speaker, to present your research; invitations to write chapters in international books; and over 22,000 citations, including 54 publications cited more than 100 times! Yet you don't say stuff that is mainstream. How have you managed to keep your reputation when you get so attacked – indeed, our editorial describes how the president of the Royal College of Psychiatrists wrote to national newspapers, saying that your latest paper would unjustifiably worry people.

READ: I do get a lot of quite vicious attacks on social media like Twitter. In our world, it comes with the territory. Recently we did a review of ECT showing that there is very little evidence for benefits and it causes a lot of brain damage, and there were about five critiques in psychiatric journals, all misrepresenting what we had said. One of the ways I deal with that is by religiously replying to every journal or individual, pointing out all the misinformation and correcting it, and that is exhausting.

The human rights struggle we are engaged in is very hard because we are going up against heavily invested forces, primarily the drug companies and a profession that some say has sold its soul to the drug companies. But, in that process, you also meet the best people in the world and that is what keeps us all going – magnificent people around the world fighting in many different ways against medicalisation of human distress. And your organisation is a part of that. ■

Denise Winn *is editor of* Human Givens *and a human givens practitioner. She is also a regular contributor to* Psychology Today *(www.psychologytoday.com/gb/contributors/denise-winn*