An Interview with Dr James Davies, author of *Cracked: Why Psychiatry is Doing More Harm Than Good*

S&S [RH]: James, thank you so much for giving up your time for this interview. Over the past few months, the whole issue of psychiatric diagnosis, and what at S&S we tend to call 'psychopathologisation', have been thrust to the fore in both media and professional circles and discourses. With your new book, *Cracked*, you've made a major contribution to what we think is a crucial cultural moment. Can you tell us something of the origins of your own interest in this field, and how you struck upon the idea of researching your book?

James Davies: Sure, I'd be happy too. My interest was first kindled when I started working in the National Health Service in 2004. Back then I pretty much accepted the mainstream view – that psychiatric drugs work, that the categories of mental disorder have been established via solid scientific research, and that we are now on the cusp of understanding the biology of mental illness. It took many years of practice and research to learn that such assertions do not stand up to serious scientific scrutiny. Once the massive gulf between what people had been led to believe about psychiatry, and what the facts actually reveal, became clear to me, I felt determined to make that gulf more widely known. So by writing *Cracked* I had the explicit intention of communicating to the general reader in an accessible and engaging way the inconvenient facts about psychiatry which most people are oblivious to.

S&S [RH]: Sounds like a fascinating journey, James. I'd like to ask you to say more about 'communicating to the *general* reader in an accessible and engaging way'; but first, could I just ask you succinctly to summarise (in a Drydean 'nutshell', perhaps!) your book – for example, what have you done in this research, and what, in essence, do you see as your key findings?

James Davies: Well, Richard, I'll try and be brief. In *Cracked* I aimed to join the dots between separate areas of research that have exposed different failings of the profession: that the construction of mental disorders in manuals like the DSM and ICD is a cultural process, not a scientific one; that antidepressants actually work no better than placebos for the majority of people; that negative drug trials have been routinely buried and research regularly manipulated to produce positive results; that psychiatrists' objectivity has been compromised by financial ties to the pharmaceutical industry, and how big pharma's mass-marketing has concealed from doctors, patients and the wider public the ethical, scientific and treatment flaws of a profession now in serious crisis. If you join all the dots you get a picture of a profession which, in the name of serving others, has often been better serving itself. My apologies if that was not in a nutshell.

S&S [RH]: That was my broad understanding, James, but it's great to have it put so succinctly. As I mentioned earlier, I'm very interested in the notion of 'communicating to the general reader in an accessible and engaging way'. As I understand it, you've published *Cracked* with a non-academic publisher. I know from some experience of the snobbery that can exist in the Academy, and that quite nasty judgements can be made about academics who choose to go down a more 'popular' route to propagate their ideas. Can you say something about the tensions that might exist between writing for academia, on the one hand, and writing *academically informed* material for a

wider, more popular audience, on the other? Is there a place for academics not necessarily studiously protecting their academic purity and respectability? And have you deliberately aimed for a writing style that tried to find a middle path between the academically pure and the popular/populist? For example, reviewers of your book on Amazon have written that there are 'lots of personal descriptions of people and settings', and that the book reads 'almost like a thriller'. Lots of questions there!... (and ones I think that are especially relevant to people within Humanistic Psychology who probably also come up against these kinds of questions).

James Davies: Well, Richard, let me put it this way. Just think who has written for a general audience – Amartya Sen, Noam Chomsky, Bertrand Russell, Richard Dawkins, Plato! What links them all is their belief that speaking beyond the groves of the Academy is an essential part of the intellectual's life. How can you inform public debate if you only speak to your professional cohort? How can you shape public opinion if you do not reach out? The topic that *Cracked* tackled is just too important *not* to be widely communicated, because drugs and diagnoses affect millions of people each year. So I told stories, I conducted challenging interviews, I wrote aspects of the book, yes, like a thriller. But I did all this in service of giving the inconvenient facts the best possible chance of getting out there. And you can do that without compromising your academic values: honouring the research, proceeding logically, not going beyond what evidence says. And even when doing this, if there are some who quietly 'tut' beneath their breath, well, you can't please everyone all the time. So for me the tension is not really an issue right now, or at least I try not to make it so. I straddle both worlds because I fundamentally believe in the necessity of both. And there are many people better than I who do the same to great effect.

S&S [RH]: A resounding response, James! – and of course one I entirely concur with; thanks for that. I think it's a crucial point to make that to enter into 'popular', or even 'populist', discourse doesn't at all *necessarily* entail a dilution of the logic and veracity of one's argument; and in any case, the idea that social science, however 'scientific', can be completely free of persuasive rhetoric and subjectivity has always been a fiction that any even cursory perusal of the Philosophy of Science literature will demonstrate.

I've found myself wondering whether you see the research underpinning *Cracked* as falling within a continuity of critiques of psychiatry, starting from Szasz and Laing, and then through people like Michael Barnett (*People, Not Psychiatry*, 1973), and then more latterly with people like Dan Burston, Ian Parker, Mary Boyle, Peter Breggin, Sami Timimi, Joanna Moncrieff, Pat Bracken and Phil Thomas.... And relatedly, would you say that there is anything new in your own research findings, or is it more that you've produced incontrovertible research evidence that now confirms what psychiatry's passionate critics have been saying for a long time?

James Davies: As for the research underpinning *Cracked*, spot on Richard – you've identified the trajectory. All critics start with Szasz and Laing to some extent. In fact, I interviewed Szasz for the last chapter of the book. Three weeks after that interview Szasz sadly died. I think mine was the very last interview he gave.... But even as we spoke I couldn't help wondering whether all that has been written since is a mere footnote to his work. I suppose in some ways this is true, ideologically speaking, but I suppose it is less true with respect to the type of critical research now being undertaken. Take the recent critical psychiatrists you have just mentioned, like Sami Timimi, Joanna Moncrieff and Pat Bracken. They have exposed psychiatry's excesses and limitations primarily by conducting new empirical research. Compared to Szasz, their work is more research than idea based. So there's one difference. Also, I think Szasz and Laing sometimes went too far in their stridency and insurgence, almost to the extent that they partly de-legitimated themselves and, in turn, their message. The recent wave of critical psychiatrists is more careful than that. This does not mean they are more deferential. They are not. It is more a matter of tone.

Now, as for where my book fits in? Well, although I offer new interpretations and interview data and weave a narrative that is my own, when it comes to the actual research I am fundamentally indebted to many of the names on your list, and many others besides. As I stated earlier, my task was to communicate existing research in a way that grabbed the public's attention. So if you want to call me an interpreter rather than an innovator in this area, I am fine with that.

S&S [RH]: You're very modest, James, but it sounds to me that you're both interpreter *and* innovator: it's easy to underestimate how difficult it is to propagate ideas like these in the public sphere in a really effective way – and with this book you've proven yourself to be a master at it, and we should all be grateful. More specifically (and I've asked you this before), how did you manage

to do those interviews with some of the 'big beasts' of orthodox psychiatry, and get them to dish so much dirt on themselves? (if that's a fair way to put it). Did they know you might be writing a critical book? Is it perhaps something about your manner that disarmed them and left them wanting to be honest with you? (almost akin to a confessional experience?). Have any of them contacted you since the book came out? Might you risk contacting them again and asking them what they think about the book?!... Too many questions... – do just pick the one(s) you'd like to answer!

James Davies: Indeed, many questions. But I now get asked these questions all the time. Why were these guys so frank with me, especially when many pressed me about my project? Well, to be honest, Richard, I am still really not sure! Maybe the time was right for them to speak, maybe I managed to put them at ease, maybe they did not see me as a threat, or maybe, as you say, there was something confessional in the experience – I really don't know. I actually remember after many of the interviews calling my wife and saying – 'Wow, you aren't going to believe what I've just heard!'. And she'd say, 'I hope your recorder was on!'. But there were other times when I'd say to her that so and so just won't return my messages, or was rude, evasive or defensive in the interview. But of course these exchanges didn't make it into the book: I'd rather disclose the powerful confessions than pontificate on why someone slammed the door on me. Whatever is the case, no one I interviewed has contacted me yet. Of course, I am happy to speak to them if they do. And as for my contacting them? – I see no reason to at the moment because I'm not so sure what it would achieve....

S&S [RH]: Well, however you managed to achieve it, James, I'm not aware of anyone having succeeded in doing this before, and in my view it's an extraordinary achievement – and one which adds something quite crucial to the existing critical literature, bringing something that cogently argued, more theoretical critiques, no matter how well formulated, just aren't able to achieve.

In an interview like this, I think it's important to at least go through the motions of a few devil's advocate questions! I've been trying to imagine myself into the shoes of a mainstream Psychiatry advocate, and to construct the most convincing arguments I can muster in favour of orthodox psychiatry. Let me try some arguments out on you, and see how you respond. One of your Amazon reviewers (who gave the book five stars, by the way) writes:

> After 30 years as a GP, this book confirmed what I had suspected all along, that doctors are carried along on a wave of misinformation and pharmacological skulduggery. The problem is that patients are also sitting on the same wave, looking for labels to justify sick leave, extra social security benefits and attention, and have no difficulty changing to a physician who will agree with them....

Now I think there's something crucial here about the possibility that perhaps the DSM diagnostic mentality is only giving many people ('patients') what they're actually wanting. And on this kind of view, might DSM apologists plausibly argue that DSM is merely a kind of 'cultural condensation' of what many/most patients are wanting, at this juncture in the evolution of consciousness? And could it therefore be that, notwithstanding all the ideology and vested interests driving the process, the DSM could be producing something that some, at least, feel or believe to be useful?

Relatedly, if we accept that there is no universal 'objective' reality, then might DSM apologists legitimately claim that their diagnostic approach is just one 'local', culture-bound 'truth' amongst many, and it will find its right 'level' amongst the many other local truths that are vying for cultural ascendancy? (I realise that psychiatrists *do* normally take up an objectivist position; I guess I'm just wondering whether they might be able to justify their practice more effectively if they were to embrace a more post-structuralist viewpoint!). There's a lot there, James – I'm very interested to hear what you make of it (or, indeed, whether you might be able to think of even more convincing rationales from *within* the logic of orthodox psychiatry).

James Davies: To argue that the DSM is useful on the grounds it gives people what they want would be rather like saying tobacco companies, cosmetic surgery clinics or even illegal drug pushers are useful because they satisfy peoples' desires and needs. In our case we are talking about the need for a label, an explanation, a diagnosis. Now some people seek these for dubious reasons, largely to do with state benefits, as my Amazon reviewer-GP pointed out. The question for this group is, why would they seek state dependency, what are the socio/psychological factors that would compel them to such a telling act? So let's look at those factors and see what we can do about them. In my experience, however, most people who seek out psychiatric labels do so for other reasons – usually because they are in peril and want help. If a doctor has a name for their condition, they surmise, then presumably the doctor can understand it and treat it. So what's sought

is understanding and help. So far, so good. But the trouble is that what is packaged as 'help' casts a dark and long shadow. A psychiatric diagnosis is a hugely powerful cultural symbol. It has such potency, in fact, that patients who are newly diagnosed actually experience a mild recovery boost right after the event. The diagnosis itself heals. This is called the 'diagnostic effect' – the idea that the diagnosis itself wields a kind of placebo effect.

But now enters the shadow, because of course the diagnostic effect is temporary. It lasts only a short time. And so what follows after? Well, as you'd guess, things start to tip in the opposite direction. Patients start so say, 'Hey, hang on a minute, I actually *am* psychiatrically unwell'. And this slowly starts to make them feel different, set apart, and lowers their opinion of themselves. They gradually stop self-identifying as a healthy participant in normal life, but now as a person not in control of their fate. They have a psychiatric condition that has seized control, rendered them different, and made them dependent. In other words, diagnoses not only regularly engender the painful self-stigmatising effects of self-identifying as mentally ill, but they also surreptitiously invite the fear and incomprehension of others (something that can only compound the sufferer's isolation).

So the diagnostic effect actually turns out to be a harmful effect. Relief turns into stigma, understanding into medication, medication into side-effects, withdrawal effects, confusing psychological effects. For these reasons, the fact that people want a diagnosis should never be the measure of how justified that diagnostic system is. The measure should rather be, to what extent does the system actually help people more than hinder them? According to this latter measure, which is the only one that counts in my view, manuals like the DSM and ICD, both in terms of how they are conceived and actually used, are often guilty of compounding the suffering with which many people present. So I hope that addresses your first point.

Now, Richard, on to your second point. My view is that the DSM and ICD panels will never admit the full extent to which their manuals are just cultural texts, two different kinds of cultural confession, if you like. After all, the legitimacy of these manuals rests on the assumption that the categories they include are broadly universal, and therefore largely transcend culture. This struck me most powerfully when interviewing Dr Robert Spitzer (creator of DSM III) at his home in Princeton. As we sat there sipping hot Thai soup, he asked me about my PhD. I told him it was in social anthropology. He looked at me for a moment before asking: 'what is *that* exactly'? He had no idea. Did you hear that, Richard? – he had no idea! So I told him. But in response he seemed unmoved and went on to suggest that he had little sympathy for the idea that mental disorders differ from culture to culture: what I inferred was that he believed that his diagnostic criteria for, say, depression, could pretty much be 'rolled out' anywhere – in a Sri Lankan Monastery, in an Amazonian tribe, in a native Indian commune. Of course all these places define suffering in ways different to our own. They also have conditions that we do not have, just like we have ones that they don't have. In our manual we call these 'foreign' or 'exotic' conditions, or in our technical language, 'culture-bound syndromes'. The assumption here is that *our* conditions (how they manifest and how they are defined) are not culture bound. Although this is obviously not the case, this view is nevertheless politically vital – the belief in universality is crucial for legitimacy, especially when you have to maintain your status in the eyes of other medical specialisms. If cancer is universal, then so too is ADHD, or self-defeating personality disorder, or mixed anxiety and depression. To allow culture too far into the equation is to let go of the biological/universal, and so to ultimately let go of status and power. And in my view that is not something psychiatric organisations are willing to do.

S&S [JM]: So, to summarise, James, institutional psychiatry is unlikely to willingly relinquish its power, and many individuals remain heavily invested one way or another in obtaining a diagnostic label. And as long as the medical-psychiatric model remains deeply embedded in society, obtaining a diagnosis remains an essential pre-requisite to accessing services for many people. Also, some service users at least seem to be making a conscious, pragmatic and personally empowering choice in the context of their own lived experience and the cultural conditions they face. From a humanistic perspective, we'd want to respect and support that choice. So how do you envisage we can get from where we are now to where we might wish to be, without 'throwing anyone under the bus' in the process? As the kind of critique we've been discussing becomes part of the mainstream, do you see the credibility of psychiatry as a way of framing the human condition being rapidly and fatally undermined, or is it more a case of incrementally bringing about a broader shift in cultural attitudes regarding the atypical experiences and/or human frailties to which psychiatric diagnoses currently point – to the extent that a less problematic and more 'humanistic' psychiatry becomes a real possibility?

James Davies: Well, Jennifer, rapid change would be

wonderful, but I'm not convinced that will happen any time soon. What I rather foresee, depending on what *we* do, are many smaller battles being waged, and hopefully won, to move us towards a more humanistic psychiatry. But for this to happen, the important battles must first be identified. So here are just a few: the battle for transparency, for improved research oversight, for better drug regulation, for more humanistic training, and for greater access to non-medical alternatives.

The battle for transparency starts from the position that nearly all research into psychiatric drugs in the UK – that's nearly 90 per cent of all clinical trials – are conducted or commissioned by the industry. Most academic drug researchers have also received research funding, consultancy fees and honoraria from the industry. In fact, Jennifer, did you know that of the 29 people who wrote the recent DSM-5, a full 21 have had strong financial ties to the industry, including the chair and vice chair? This is absolutely unacceptable, least of all because research shows that doctors who receive such payments are more likely to be biased in their clinical activities and beliefs than doctors who don't. And yet, right now in Britain, doctors are not obliged to report to any agency or to any authority precisely how much they personally receive each year from the pharmaceutical industry. This has to change. We need an online register where all payments are made freely transparent to act as a restraint on some of the more unscrupulous behaviour. Without such transparency, vested pharmaceutical interests will continue to shape our mental health provision, without people even being aware of it.

Then there is the battle for better research oversight. We know that industry-sponsored drug research has regularly transgressed the bounds of what is right and proper. From class actions taken against many different pharmaceutical companies, and from comprehensive academic studies, we know that negative trials into psychiatric drugs have been routinely buried. We also know that company research has often been manipulated to turn negative results into positive ones. What we therefore need right now is an independent research agency that scrutinises all clinical trials for methodological shortcomings and bias, and that ensures all trials, negative or positive, are made freely accessible to the wider research community.

This moves us on to the battle for better drug regulation. Right now, the safety and efficacy of psychiatric drugs is assessed by the Medicines and Healthcare Products Regulatory Agency (MHRA). But the MHRA is itself *entirely funded* by the pharmaceutical industry, and currently only requires two positive clinical trials to approve a psychiatric drug for public use, even if five or ten negative trials exist. In a practice that will bemuse many readers of *Self and Society*, the MHRA discards the negatives. This seems wrong to me because science is all about probabilities, so if you exclude certain negative data then it's likely that the result will be skewed in a positive direction. We therefore need serious questions to be raised about whether it is right for an agency that's responsible for assessing the safety and efficacy of pharmaceutical drugs to be entirely funded by the companies who make these drugs.

We also need more humanistic, non-medical psychiatric training. We are so behind in this area. A study published a few years ago showed that 91 per cent of all psychiatric trainees had not satisfied the training criteria for psychotherapy by the time they had reached their Royal College examinations. This speaks volumes about the continued dominance of the medical model in psychiatric training. Until the next generation is made more familiar with the excesses and limitations of the current system, the next generation is in danger of simply replicating the mistakes of the past.

Finally, we need more provision for alternatives, more therapy, more patient peer support, more social and non-medical interventions. This is woefully under-funded in the National Health Service, where one in five patients have to wait over a year to receive some kind of talking therapy, and the remaining four often many months. Only 8 percent of patients are given a choice of treatments, which is a sad figure, given that patients improve more quickly if they have a say in what kinds of treatments they receive. In the absence of there being alternatives, it's little wonder that the medical model gains in strength, year on year.

So here are a few things that we can get started on right now, start lobbying about, start writing about, start fighting for – which will make a real difference. We need the therapeutic and academic community to get behind this; to start becoming more political, vocal and confident in its opposition. This kind of activity is still not vigorous enough, but the time is ripe for that to change: the time has passed for deference, for fear, for hesitance. We need to start speaking up, and speaking out loudly.

S&S [JM]: So, James (and I'm asking this from some experience of the 'user' perspective), the implication of what you've said seems to be that you think there is at least the potential for a resurgence of radicalism out there in

the field, but that some broadly humanistic practitioners, possibly even a majority, have in the past kept their heads below the parapet and done what's expedient, rather than take the risk of challenging the status quo from a principled, politically aware position. Assuming that is the case, and there is arguably a growing perception that it is (not least on the part of some increasingly well informed and politically savvy service users), doesn't the therapy profession need to be more transparent about acknowledging its own history of self-serving political inertia, if any new upsurge of radicalism is to have real credibility, particularly with those who have been poorly served or even damaged in the past? And if so, do you see any evidence that this kind of 'truth and reconciliation' process is taking place?

James Davies: Well, Jennifer, one of the main charges against certain forms of psychotherapeutic humanism is that they were too apolitical. Changing the external world came second to changing oneself. This was justified on the grounds that if enough people became actualised, then spontaneous social change would follow. The personal, in effect, became the site for political struggle. But the trouble with this view is that it bred in many a kind of self-obsession with growth and consciousness, while the world bled around them. The time of spontaneous change didn't come. Instead, capitalism became more aggressive, corporations more corrupt, the natural world more polluted.

Of course there are other strains of humanism that make political action vital, and which tend to see growth as something which emerges as much from humane action as from introspection. What we now need is this political side of humanism to come to the fore. For example, with respect to changing mental health provision, instead of just meeting at conferences where we bemoan the current state, rather like old friends at the end of a dinner party, we need to meet our Members of Parliament, start petitions, hold rallies, lobby the press, write pamphlets, do the research, and so on. If patients see this happening, they will get behind us. But it's not happening to anything like the extent we need. This is why patients themselves are now starting to take the lead, doing the work we should have been doing. I can't tell you how many emails I've received from people saying '... so what next? We've identified the problems; what are *you* going to do about it? We need your expertise, your influence, your position on the inside, your help!'

S&S [RH]: Alas, all good things must come to an end, James – and I think most if not all of our readers will see both this interview, and the work you're doing more generally, as a very 'good thing' indeed! Shifting *Zeitgeists*, and how such deep paradigmatic change can happen, is one of my own core interests and concerns, and it seems to me that with this vital work you're doing, this is the game you're currently immersed in, too. This final question might be a mite premature, James, but from the experience you've had to date with the work around *Cracked*, can you say something about what you've learnt about ways of going about (and, perhaps, not going about) the *challenging of prevailing paradigms*, and what needs to happen (necessarily and sufficiently, perhaps) for such deep and sustainable cultural change to occur? And before you answer this final question... – can I thank you so much on behalf of *S&S* for taking the time to create this enthralling interview with us: it has been a revelation and a pleasure to be involved in it. So thank you again! – and we wish you all possible success in your future work.

James Davies: Well, thank you Richard for having me! But before I go, now to your final question. I hesitate to name what I have learnt because, as you say, it is still early days. So I suppose all I can say now is what has helped me thus far in the subsequent psychiatric debates I've engaged in since publication: above all, know your facts! They have saved me from many a potential tricky situation. Furthermore, so long as we don't go beyond what the research allows us to say then we are safe. The sad news is that the research allows us to say some pretty shocking things about how the current systems is often harming in the name of healing. So in a nutshell, always have a secure base if you want to challenge any powerful system, make sure your opposition is rooted in fact, not bile or bias. That way, you neither undermine yourself nor the argument for which you're temporarily a spokesperson. This last point is crucial. Many great ideas have failed by being taken up in the wrong hands. This thought has often kept me up at night, given what is stake.

So thanks for the opportunity, Richard and Jennifer, I've enjoyed our exchanges very much.

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