

The Evidence Game **Craig Newnes, Shropshire County PCT**

Evidence is all around us. But not the evidence of our senses, you understand. The new evidence in the NHS is the evidence of "evidence based practice" and "evidence based medicine". Before the days of evidence based on this and that we are asked to believe that professionals didn't bother with anything as substantial as training or reading research. There is some truth in what the new evidence lobby suggests. After all, there are practitioners who have studied little but other people's navels since qualifying; there remain unsupervised and poorly tutored professionals. The idea that most mental health professionals pay no attention to scientific journals is, however, patently absurd. Sadly, professionals spend valuable time ploughing through the worst kind of pseudo-scientific writings. Scientific journals consistently give a mechanistic view of therapy and humanity that seems to have no place for the complexity of relationships or the overwhelming absurdity of attempting to systematize these relationships.

Worse, many psychiatric journals are little more than drug company propaganda. For those who do read the latest research there are major questions about the ways in which it is funded and results disseminated. Reported research is only a fraction of that carried out, and it is invariably only the results that suit the vested interests of researchers or sponsors which appear. NICE are bedeviled by accusations of self-interest amongst its various expert panels. A recent government publication, **Effective Health Care**, in reviewing the newest so-called anti-psychotic medication concluded, "Most relevant trials are undertaken by those with clear pecuniary interest in the results" (December, 1999). Furthermore, the research is of a particular, very narrow, type (so-called Randomized Controlled Trials), and light years from what actually happens in everyday clinical practice. The bible of psychiatry, the Diagnostic and Statistical Manual, is actually a catalogue of loosely clustered conduct that people don't like rather than a real medical text. Putting it bluntly: much so-called science is a con. There is more to life (and therapy) than the categorization of people into diagnostic entities or personality types and the application of theoretical models of change derived from the laboratories of psychologists and pharmaceutical companies. We need a greater acceptance of a far broader range of evidence than is the case at present with a particular emphasis on what might be described, or even decried as, non-scientific evidence; the evidence of literature, our senses and personal experience.

Some years ago, I came across an article on the desirability of moving clinical psychologist expertise into the world of the cancer sufferer. The article was brief and well referenced. These references included the Journal of

Psychosomatic Research, the Journal of Psychosocial Oncology and many others all, no doubt, prestigious examples of the scientific approach. My partner had recently received a secondary diagnosis of lung cancer. Neither she nor I sought solace or information in these journals. We had already read, some twenty years before, Solzhenitsyn's **Cancer Ward** and knew that hospital visits would be marked by waiting alongside grey-faced, anxious people and their forlorn lovers and relatives. I knew that the wards would be terrible places where emaciated people would barely glance up as we came in and side-rooms would be reserved for the middle-classes and the dying. I had already known, like Solzhenitsyn's Aysa, the moment when a breast would be offered up for kissing one last time as, "Today it was a marvel. Tomorrow it would be in the bin." And I knew all this at fifteen. I can't even remember the authors of the article on clinical psychology and cancer but **Cancer Ward** stays with me still.

As does Douglas Dunn's **Second Opinion** in which the narrator notices, with understated envy, the wedding ring of the junior doctor tasked with breaking the news of his loved one's spreading cancer. Somehow, this no longer counts as evidence; lived experience, literature, poetry, the realm of our senses. It is a real challenge for the pseudo-scientific community of psychology and psychiatry to embrace the commonplace wisdom of philosophy, literature, poetry and personal experience. There is a vast supply of such wisdom out there. There are good textbooks on the human condition (Judith Shklar's **Ordinary Vices** or Dorothy Rowe's **Wanting Everything** spring to mind) but if psychology and psychiatry are to take their subject matter seriously then Dickens and Zola (**Hard Times** and **Germinal**, respectively, cover class oppression pretty exhaustively) should be compulsory reading. The angst, desperation and anxieties of the middle classes are described throughout Balzac's **Comedie Humaine**. The power of faith is to be found in Greene's **The Power and the Glory** while murderous hate is no better explained than in Mailer's **The Executioner's Song** and **The Collector** by John Fowles. Drunkenness and domestic violence inhabit **The Woman Who Walked Into Doors** by Roddy Doyle and Lorna Sage's **Bad Blood**.

The list goes on and on. You might prefer Eastenders or The Simpsons. You might even prefer a well-written science textbook. The point is that if it makes sense to us then it is evidence. Professionals need to respect the evidence from literature as of at least equal importance to the evidence presented in scientific journals and at scientific conferences. Novels have at least one considerable advantage over scientific writing; the former are presented, honestly, as fiction. The meanings and lessons derived from novelists are clearly the personal constructions of the reader from material not masquerading as fact. Evidence presented in scientific journals, supported by statistical analyses of bewildering complexity, is meant to be the truth: if it makes no sense to the reader, then the reader is seen to be at fault. If we take seriously the evidence of our senses then there are paradoxes to be found at

every turn: the decent psychiatrist who sees little reason to stop using ECT, the general practitioners who wouldn't dream of taking drugs (any drugs) themselves but who willingly give out repeat prescriptions of major tranquillisers, the psychologists who claim, publicly, to work as evidence based scientist practitioners, but in private admit that they have little evidence for anything, the people who espouse the benefits of multi-disciplinary teams but protect their clients from team members they do not trust. Contradictory and confusing experiences abound in the world of the mental health professional.

Mental health students rapidly discover that some psychotherapeutic techniques work quite well. More confusingly, they also discover that some people feel a lot better after only one or two sessions of what the student had seen as a rather stumbling attempt at a chat. In fact, hospital in-patients seem to feel better by talking with other patients. What are students to make of this? The scientific literature has something to say about this in terms of the dose-response curve in suggesting that the greatest impact of therapy is to be found in the first two sessions. Common sense has a different slant: "A problem shared is a problem halved". Talk to someone twice and, presto! Your problem is reduced to a quarter and easily manageable. Professional notes are full of material, never cross-referenced, about common factors in human misery. We notice, again and again, that people taking so-called anti-depressants are still depressed or people taking major tranquillisers are stoned most of the time. We notice the smell on wards and feel frightened when visiting institutions for the first time. We feel confused at ward rounds and can't follow the logic of organic theorizing. Conversations with colleagues about the terrible circumstances of people's lives, the frequent remarks about so-and-so's parents in the waiting room, the way a supervisor respects colleagues or upsets supervisees: this is all evidence. It all counts. It all influences the way we work. We are, quite literally, surrounded by evidence.

Psychologists, psychotherapists and counsellors in training can be warned against consciously using personal experience in case it makes us less objective or emerges as counter-transference. Of course experience of any kind, be it childbirth or monitoring biorhythms during behavioural experiments can only be subjective. Professionals need to recognise and utilise their subjectivity. We are parents, lovers, partners, children, men and women as well as psychologists. We will have loved, lost, betrayed, envied, suffered and survived. We have all used the health service. We are gendered and politicised. We will have used, or love people, who use services like the ones we offer. We may have been diagnosed. We are all oppressed and can oppress.

My own field, clinical psychology, is not a desert when it comes to discussing personal experience and the usefulness of art and literature. In its in-house journal, however, less than three per cent of papers in the last ten years

explicitly engage with the personal and fewer still have explored how it feels to sit with or attempt to help people in distress. The proportion diminishes dramatically if this kind of writing is considered in relation to the thousands of articles published in journals requiring statistical means to determine what is evident. It is also obvious that in psychiatric practice psychiatrists prefer an essentially experiential approach. They talk with patients about drugs that suit them and try to negotiate combinations of drugs that balance the desired with the unwanted effects. They use, on a daily basis, the evidence presented by the patient. What they tend not to do, is to collect and respond to the evidence that vast numbers of their patients live in circumstances that they would find overwhelming, circumstances that drugs cannot possibly change. And there remains, within much of psychiatry, a rather naïve belief that drug company sponsored research and training is unaffected by the sponsor.

The way forward We need more mental health professionals prepared to take their own experiences and the experiences of patients seriously. Training courses should employ far more service recipients as lecturers. Professionals need to be better read and more willing to criticise the scientific writings that saturate their training. Departments of psychological therapy and clinical psychology should have easy access to a full range of literature. If they hold library resources and budgets then these should reflect as many attempts as possible to capture human dilemmas and difficulties, from film to poetry, from text books and scientific journals to novels, autobiography and philosophy texts. Many clinicians already recommend novels and poetry to clients and are offered literature by clients attempting to illustrate their difficulties.

These exchanges should be encouraged. Clinical and service research should be based on the lived experience of service users rather than utilising test instruments developed in academic psychology departments using paid undergraduates as research subjects. This research should be controlled and directed by service users and survivors themselves, rather than by the pharmaceutical industry. It is time to celebrate subjectivity, admit to our humanity more often and embrace arts, literature and lived experience. That should be enough evidence for anyone