

The fool on the hill

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The spinning chair. Bloodletting (copious). Removal of possibly infected viscera. Extraction of teeth. Electric shock. Forcible restraint, for days or weeks. Wrapping in cold blankets. Brain damage. Repeated coma. Back-breaking convulsions. Slicing through the brain with an ice pick. Sterilisation. Female genital mutilation.

Since the Enlightenment, all the above have been used to treat the “mad”. Even the most grotesque treatments have often been introduced as humane alternatives to existing options. In the 1950s, the chemical lobotomy, or “hibernation therapy” was introduced. Patients were given a drug that rendered them immobile and semiconscious for days, on the assumption that they would emerge improved. The drug was called a “neuroleptic”, or brain restrainer. Its name? Chlorpromazine. Since marketed as an antipsychotic, it is used, at lower doses, today. So too are a host of related drugs. Many doctors, and some patients, swear by them (other patients swear at them).

Antipsychotics are, at times, cruel drugs. Some cause shaking, salivation, restlessness, infertility, stiff ness, agitation, and frail bones; others cause obesity, somnolence, and increase the risk of heart attack, diabetes, and stroke. Antidepressants also have side-effects, although theirs are typically less dramatic: sickness, sexual dysfunction, a feeling of being numbed, or losing one's personality, and acutely increased risk of suicide. But side-effects, when they occur, seem justified, since mental illness is extremely unpleasant; and evidence indicates that the drugs work.

What if they didn't? *In The Myth of the Chemical Cure: A Critique of Psychiatric Drug*

Treatment, psychiatrist Joanna Moncrieff has amassed copious evidence that perhaps the drugs don't work. What have we missed, all these years? Selective and misleading outcome measures; inadequate follow-up; selective attention to evidence; publication bias; and our ability to define questions whose answers are predictable, but partial. Robert Whitaker's *Mad in America* (2001) provided a breathtaking overview; Moncrieff, by contrast, examines many studies in detail. *The Myth of the Chemical Cure* is not always easy reading, but I do not think that serious psychiatrists can afford to ignore Moncrieff's book. It is a mine of information; a provocation to think creatively and compassionately about patients; and a *memento mori*, the equivalent of a mediaeval scholar's skull staring back from his desk: our works are mortal, and our paradigms always limited.

Psychiatrists are widely regarded (and not just by other psychiatrists) as insightful and intelligent people. How can systematic research errors influence practice? In *Side Effects: a Prosecutor, a Whistleblower, and a Bestselling Antidepressant on Trial*, Alison Bass illustrates the method. The book lacks a little in intensity; it could be shorter than it is. However, it manages to illustrate that drug companies fund and design research; academic advancement depends on procuring research grants; and, especially with materialist approaches to the mind requiring expensive tools, ambitious doctors often have little choice about the paymaster. Bass indicates, as William Broad and Nicholas Wade did many years ago, that research fraud is not merely anomalous, but the result of pressures placed on academics, some of them self-generated. Even in the absence of research fraud, the mechanisms of research would often not be conducive to original or patient-centred thinking. Moreover, acceptance of (in retrospect) bizarre and cruel remedies predates the growth of the pharmaceutical industry.

This occurs although psychiatry, of all disciplines, ought to be based on the art of listening. A patient's story is a symphony of suffering, longing, meaning, understanding, hope, fear, loss, wit, and wisdom. Not to accompany the person afflicted on his journey is inhumane. People will always need psychiatrists. But do people always need psychiatry? Instead of the art of expert companionship, psychiatry has become the discipline of brain mechanics. Experiences are matched to labels of descriptive poverty. "Depression" implies a low level of something, presumably mood, rather than the rich and complex turmoil felt by the patient. "Schizophrenia" means several contradictory things, but does not reflect the search for meaning that is at the heart of the disorder.

Is it a disorder at all? Madness is to sincerely hold beliefs that society regards as insupportable. But no society's knowledge is complete. Our ancestors would regard us as mad, or, charitably, as ill-informed; we observe with relief that we do not share all their beliefs. Healthy societies have often regarded at least some madness as serendipitous. If reason follows from incomplete assumptions, madness, by outflanking reason, can complete the human picture. The notion was enshrined in the King's Fool: a measurelessly eccentric, often holy, man who told the state, embodied in the king, what it otherwise could not hear (the tradition died out in Britain after Charles I was deposed, not long after his fool was expelled from court, at the behest of a jealous archbishop). Our assumption that madness is necessarily a disorder assumes that we are necessarily sane. I

would hate to make that an article of faith.

In focusing on, and stigmatising, people with mental illness, we tend to ignore the context. In our fervour to understand mental illness, we have applied grossly oversimplified biochemical models to the brain, with usually unhelpful results. The search for a “schizophrenia gene” has been heroic and, so far, labyrinthine; but to be black, isolated, and urban in the UK increases the risk manifold. Society, and circumstances, can drive people mad; the epidemic of depression and anxiety is otherwise inexplicable. To focus research on the person who has become ill can be a little like concentrating on a damaged house after a tsunami has hit a village. The cause may be elsewhere.

Some would argue that even if drugs work, they do not work. The margin over placebo is not large; the number needed to treat is not vanishingly small; prognosis may be worse than with the “moral treatment” (rest, respect, good food, work, prayer) of 200 years ago; patients' adherence, especially to antipsychotic drugs, is patchy; drug treatment attends to the symptoms, but not to the human being who has the symptoms. We would, as a society, achieve a great deal by listening to patients' demands for good food, companionship, respect, practical support, and gainful activity. As doctors, being with the patient is one of the most powerful healing tools we have. It can sound trite; but the phrase describes receiving the patient's humanity, and allowing it to come through crisis intact and enriched, without the loss of dignity and self almost inherent in labelling. We rarely have the time, or encouragement, to treat patients according to their story, rather than our diagnosis; outcome measures are too coarse to consider whether the patient has been allowed to preserve and fulfill his or her humanity. The work of Moncrieff and Bass is a warning that the doctor must be intellectually and morally free.

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Books reviewed:

- *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment* by Joanna Moncrieff (Palgrave Macmillan) 2008. 296 pages. ISBN 0-230-57431-9.
- *Side Effects: a Prosecutor, a Whistleblower, and a Bestselling Antidepressant on Trial* by Alison Bass (Algonquin Books) 2008. 260 pages. ISBN 1-565-12553-3.