It's time to rethink our thinking about mental health problems

Richard Lakeman questions perceptions of mental illness and our reliance on medication

Health professionals frequently assume that medication is a benign response

I commenced my training as a nurse in 1987, the year that Prozac was launched in the United States. The year I qualified, President Bush (the first) proclaimed the 1990s 'the decade of the brain'. Rapid change was the one constant in my experiences of working in public mental health services and a similar pace of change has occurred in relation to societal attitudes towards mental health problems. Public health campaigns around the world aimed to reduce the stigma associated with seeking help or having mental health problems. The most popular approach to this in the 1990s was the promulgation of the message that 'mental illness was like any other'. This captured the zeitgeist of the time, and many people expected confirmation of the biogenetic basis of mental illness through advances in neuro-imaging technology and the soon-to-be completed unraveling of the human genome. However, rather than wait for the proof to arrive of mental disease or distinct disease processes, such speculation has been treated as fact by authoritative spokespeople in the mental health industry.

Even a fairly cursory review of the press releases and publicity that have emanated from esteemed mental health organisations might lead one to conclude that widely known syndromes such as schizophrenia and bipolar disorder (if not the entire taxonomy of mental disorders in the *Diagnostic and Statistical Manual* (DSM-IV TR)) are clear-cut, lifelong brain diseases. One might also be forgiven for believing that we are in the throes of a global pandemic of mental disease with at least a quarter of the world (probably more) being likely to be mentally ill and in need of (pharmaceutical) treatment at some time. However, a critical, careful and scientific reading of the evidence to date would lead one to be more cautious about such claims. Despite a concerted effort on the part of researchers, no new biological markers have been found for common mental health problems that might unequivocally confirm them as biological diseases since syphilis was found to be responsible for general paresis of the insane in the 19th century. Scientists have tried to find tangible evidence to confirm the various chemical imbalance hypotheses and if anything these simplistic ideas (e.g. that schizophrenia is a result of too much dopamine and mood problems of not enough serotonin) have been found wanting (Whitaker, 2010). This is not to say that efforts have been in vain as we now know much more about how the brain is affected by stress and trauma (Nutt and Malizia, 2004), but to characterise mental health problems at this point as brain diseases is simply premature and belies the incredibly complex interplay between the environment, our relationships and our biology.

The message that people's behavior is explained by a disease may reduce the sense that people are blameworthy for their behavior but it does little to reduce other people's fear as people may be seen to be out of control. People diagnosed with schizophrenia continue to be stigmatised and feared in some places (Read et al, 2006). Nevertheless, the idea of various states of mind being a result of some kind of 'chemical imbalance' has taken hold of the public imagination. In recent years the class of drugs called selective serotonin reuptake inhibitors (of which Prozac is

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but one) have become the most prescribed and profitable drugs in the United States (Cohen, 2007) suggesting that people have literally bought the message. This, it might be added, at a time when the efficacy of the so-called 'antidepressants' has been found to be only marginally better than placebo (and not clinically significant) in all but those with the most severe forms of depression (Kirsch et al, 2008). People are seeking help for depression and unhappiness in primary care and this is what many experts in my own area of interest, suicide, recommend that people do. Beautrais et al (2005) for example, assert that mental disorders (particularly mood problems and substance misuse) play the strongest role in the aetiology of suicidal behaviour. It stands to reason that getting timely help for such problems ought to be an imperative and indeed de-stigmatising seeking help for depression is a part of every suicide prevention strategy. However, what isn't quite as clear is what 'the' aetiology of mental disorder actually is.

Health professionals frequently assume that depression has a biological aetiology, or at least that providing medication is a benign response. Up to 75% of people diagnosed as depressed (regardless of severity) receive a prescription for an antidepressant (Sleath and Tina Shih, 2003). Whitaker (2010) has recently proposed that far from being benign, the indiscriminate long-term use of psychotropic drugs for common mental health problems might actually make things worse for many people and account for dramatic rises in disability from mental health problems. It is now widely accepted that the once enormously popular anti-anxiety drugs can lead to dependency and dangerous withdrawal syndromes, and when used for long periods make treating the original or underlying problems more difficult. Whitaker (2010) argues that drugs might have some positive effects in the short term but for many people the long-term use may exacerbate and contribute to illness and disability. A further concern I have regarding this turn towards biogenetic rhetoric and emphasis in academic circles, and emphasis on medication and compliance in clinical practice, is that it might stop people from identifying and effectively addressing their problems.

Prematurely concluding that a problem is biological or communicating to a patient that he/she has a disease amenable to medical treatment may suspend or foreclose on opportunities to explore, develop an understanding and find a solution to people's problems. Until relatively recently this suspension of judgment has been at the heart of psychiatric practice as illustrated by MacNiven:

> *'The conception of a mental illness is very difficult for the ordinary person to grasp. To explain that the patient's symptoms need not have any demonstrable physical basis is not always easy, even when one is dealing with well-educated people. The natural desire to find some cause for the changes in the patient's personality leads them to believe that the symptoms must be caused by 'something on the brain' or by 'poisoning his system'. Not infrequently they have been encouraged in these ideas by the physician who treated the case before it came to the psychiatrist.'* (MacNiven, 1928: 239)

How foreign these words appear today after a mere two decades of talking-up and normalising medicating (but not actually finding 'something on ...') the brain. The author goes on to discuss a detailed assessment and attempt to find the best way to formulate the person's problem through the formulations of the person, their family, and other health professionals. That so many people do now take psychotropic drugs and return for repeat prescriptions without any degree of coercion probably does indicate that people feel better for taking them, but it does not mean that people have necessarily found the best way to frame and resolve their problems. Cohen (2007) described a person who was depressed at least in part because she and her partner were facing bankruptcy. Apparently she is no longer depressed, but is bankrupt—the latter outcome might have been avoided if the problem was framed as a financial rather than a mental one. I suggest that the best route is not necessarily the shortest or the least painful. We need to rethink mental distress, illness and disorder. As professionals we need to rediscover the idea of complex case formulation, as societies we need to acknowledge the complex socio-cultural contribution to the distress of individuals, and as individuals and citizens we need to reject overly simplistic biogenetic explanations for our behaviour and seek to account for our lives and understand them. As Socrates is purported to have said 'An unexamined life is not worth living'. Psychiatry and psychology offers a secular way of examining ones' life but our challenge is to make people's life worth living. The best way to do this, in my view is to eschew simplistic biogenetic explanations for human behaviour and rediscover bio-psycho-social-spiritual explanations that were an illustrious part of the helping professions for the best part of the last century. BJW

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