AN ILLNESS LIKE ANY OTHER?

The disadvantages of equating human suffering with a physical disorders

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My personal journey to disillusionment with psychiatry

• PHASE I: Collusion (1980s)
• PHASE II: Seeking change from within (1990s)
• PHASE III: Recognition of need for a paradigm shift (2000s)
‘Illness like any other’ – assumptions

1. Mental health problems are essentially the same as physical illnesses
2. The range of human suffering is primarily caused by a genetic brain defect
3. Once severe mental illness is diagnosed, direct intervention at the biological level is necessary
4. A clear boundary exists between the mentally ill and other people
‘Illness like any other’ – widely accepted

- American National Institute of Mental Health (2014)
  ‘Depressive illnesses are disorders of the brain …’
  ‘Schizophrenia is a chronic, severe and disabling brain disorder’
- National Alliance on Mental Illness (2014)
  ‘Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions …’
- SANE (2015)
  ‘People with schizophrenia have differences in their brain biochemistry that might cause the illness’
'Illness like any other’ – lack of evidence for

• Despite frenetic research activity stretching over half a century, NO PRIMARY BIOLOGICAL CAUSE FOR MENTAL ILLNESS HAS BEEN FOUND
Disadvantages of ‘illness like any other’ assumption

AN ENGINE-ROOM FOR MUCH THAT IS UNHELPFUL & DAMAGING ABOUT CURRENT PSYCHIATRIC PRACTICE
Disadvantage 1: More stigma

- In 11 out of 12 studies, biogenetic explanations lead to more negative view of the mentally ill (c.f. psychosocial explanations) (Read et al., 2006)
  - reluctance to befriend/be romantically involved with (Golding et al., 1975; Read & Harre, 2001)
  - increased perceptions of dangerousness & unpredictability (Read & Harre, 2001; Walker & Read, 2002)
  - viewed as a childlike, non-person (Sarbin & Mancuso, 1970)
Disadvantage 1: More stigma con...

- encourages harsher behaviour towards (Mehta & Farina, 1997)
  - Diagnostic labelling (implying biological deficits c.f. medical)
  - associated with perceptions of increased seriousness (Cormack & Furnham, 1998)
  - more rejection (Sarbin & Mancuso, 1970)
  - underestimation of social skills (Read & Haslam, 2004)
  - viewed as more dangerous, and socially excluded (Angermeyer & Matschinger, 2003)
Disadvantage 2: Encourages passivity

• If biochemical imbalance in brain is the cause, makes sense to obediently follow expert instruction

• Biogenetic explanations leads to a sense of having no control over a problem (Fisher & Farina, 1979)

• ‘Accepting’ schizophrenia diagnosis leads to perception of less control (Birchwood, 1993)

• Negative symptoms as a core part of schizophrenia – expectation of passivity
Disadvantage 3: Risk aversion & defensive practice

- Patients not responsible for their actions – risk must be externally managed
- Cumbersome risk assessments & inquiries that assume the patient with mental health problems had no agency at all (Szmuckler, 2000)
- Fuels the culture of blame (Morgan, 2007)
- Defensive practice = bureaucracy ++
Disadvantage 4: Pessimism & low expectation

• How can optimism be encouraged in a context where it is assumed that a person’s distress is a product of brain disease?

• Diagnostic labels lead to greater pessimism about recovery (Angermeyer & Matschinger, 1996)
Disadvantage 4: Pessimism & low expectation

• Service user feedback

1. Professionals inclined to view serious mental illness as a life-long condition (Lester et al., 2005)

2. Assumptions of chronicity; professionals telling their charges that they would require support and medication for rest of their lives (Kartolova-O’Doherty & Doherty, 2010)

3. 40% of all psychiatric patients had received a hopeless message, the main source being professionals (Faught, 2012)
Disadvantage 5: Overuse of medication

- Fantastical world of ubiquitous mental illness and chemical cures
- An explosion in prescribing (Ilyias & Moncrieff, 2012)
  1. Antipsychotic prescribing in England increased by average of 5.1% per year between 1998 & 2010
  2. Antidepressant prescribing in England increased by 10% per year between 1998 & 2010
Disadvantage 5: Overuse of medication

- An explosion in prescribing (IMS Institute of Healthcare Informatics, 2012)
  1. In the USA, in 2011, 3.1 million people prescribed antipsychotics at a cost of $18.2 billion
  2. In the USA, in 2011, 18.5 million people prescribed antidepressants at a cost of $11 billion
Disadvantage 5: Overuse of medication

• Negative consequences of long-term antipsychotic use

1. Movement abnormalities (Breggin, 1991)
2. Tardive dyskinesia (uncontrollable movements of hands, face, lips & tongue) – atypicals only slightly less potent (Correll & Schenk, 2008)
3. Excessive weight gain (Rummel-Kluge et al., 2010)
4. Elevated risk of heart disease, diabetes & stroke (De Hert et al., 2012)
5. Brain shrinkage/brain-cell degeneration (Cahn et al., 2002; Ho et al., 2011)
Disadvantage 5: Overuse of medication con ... 

• Negative consequences of long-term antidepressant use (Moret et al., 2009)

1. Sleep disturbances
2. Sexual difficulties
3. Nausea & headaches
4. (Less commonly) muscle cramps, seizures & gut bleeds
5. Habit forming (Double, 2011)
Disadvantage 6: Lack of compassion

- Historical atrocities (Sidley, 2012)
  1. Leeches, laxatives & emetics (Benjamin Rush, late 19th century)
  2. Genital mutilation (Henry Maudsley, late 19th century)
  3. Surgical removal of teeth, testicles, ovaries & colon (Henry Cotton, early 20th century)
  4. Insulin-induced comas (Manfred Sakkel, 1930s – 1950s)
  5. Brain mutilation/leucotomies (Egan Moniz, 1935)
  6. Electro-convulsive therapy (Cerletti & Bini, 1938 to present)
Disadvantage 6: Lack of compassion con...

- Invalidation of some forms of distress if deemed not to have ‘a genuine mental illness’
- Legalised discrimination: the Mental Health Act (Szmuckler, 2010)
  1. Incarceration without trial
  2. Community Treatment Orders
  3. Advance Decisions ‘trumped’ by Mental Health Act
How might we improve the mental health of the population?

- Expanding & promoting existing elements of good practice
  1. Recovery approach
  2. Greater proportion of people with ‘lived experience’ in the workforce
  3. Meaningful service-user involvement
  4. Easy access/informed choice re. range of interventions to reduce distress
  5. More effectively challenge the dominant medical approach (Boyle, 2013)
  6. Informed decision making around medication (Moncrieff, 2013)
How might we improve the mental health of the population? con …

• Whole system transformation

1. Focus on promoting wellbeing (not treatment of mental illness)
2. Shift primary responsibility for addressing human suffering away from the NHS
3. Much more emphasis on primary prevention
4. A governmental ‘Department of Wellbeing’?