Atlas paper- for BPS Psychotherapy Section Review

The past and future of psychiatry and its drugs

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July 2020

I am delighted to be able to contribute to this issue on my work. It has provided a useful stimulus to think about what my ideas about drug treatment mean for the future of psychiatry, and more broadly for the care of people classified as having 'mental health problems'.

The implications of theories of drug action

My theory of drug action is obvious and undeniable on the one hand, but on the other it is profoundly challenging to mainstream psychiatry and its assumptions about the nature of mental disorder and how it should be treated. It is not possible to deny that psychiatric drugs cause mental and physical alterations to normal functioning, nor that these are likely to interact with the behaviour, expressions and feelings we refer to as mental disorders. This is what I have called the 'drug-centred' model of drug action, and if we accept that it is even credible, it challenges the currently accepted 'disease-centred' model that suggests that drugs work by modifying some underlying biological mechanism that is involved in producing the symptoms of the disorder (Moncrieff, 2008, Moncrieff & Cohen, 2005).

Some of the drugs prescribed in psychiatry have stronger effects than others. Most people who take a dose of haloperidol can feel the alterations it produces pretty quickly, but those produced by an SSRI, for example, are much more subtle. An interesting property of mind-altering substances is that people are not always able to appreciate or communicate the changes they experience while they are under the influence of the drug. In David Healy's fascinating study of the effects of droperidol in volunteers, for example, people were only able describe the complex emotional and cognitive alterations they had experienced after the effects of the drug had worn off (Healy & Farquhar, 1998).

The characteristic ways in which drugs like neuroleptics change normal thinking, emotion and behaviour were welcomed by the psychiatrists who first prescribed them, who recognised that it was these very alterations that were responsible for the beneficial effects the drugs seemed to produce in people who were acutely psychotic or disturbed for other reasons. As French psychiatrist, Pierre Deniker, remarked, drugs that diminish people's responsiveness to their environment in general can cause people who are in a psychotic state to lose interest in their delusional preoccupations (Deniker, 1960).

This drug-centred model of drug action was soon abandoned, however, not because of empirical evidence supporting the disease-centred model, but because it came to be profoundly challenging to psychiatrists' views of themselves and their practice. Psychiatrists have always been deeply insecure about their medical status. As general medicine started to discover effective and disease-specific treatments during the 20th century, it became increasingly important for psychiatrists to present themselves as having sophisticated treatments that targeted underling biological mechanisms (Moncrieff, 2008). The idea that drugs target an underlying biological defect is one of the strongest justifications for claiming that mental disorders emanate from the brain or the body, just like other illnesses. Concrete evidence of a causal association between biological variations and symptoms of mental conditions is lacking, or at best inconclusive. Therefore challenging the idea that the drugs target an underlying disease or symptom-mechanism makes it difficult to maintain the notion that

mental disorders are akin to medical conditions and to assimilate the practice of psychiatry to that of medicine.

Although the drug-centred model of drug action challenges the notion that mental disorders are medical conditions, it does not deny the utility of pharmaceutical interventions and hence of forms of medical knowledge. The drug-centred model suggests that the alterations some drugs produce may be useful in suppressing the manifestations of mental distress in some situations. This approach demands a better knowledge of psychopharmacology, as understood in a drug-centred framework, than most psychiatrists currently have. It demands that professionals have a comprehensive understanding of the phenomenology of drug-induced alterations and how these might interact with different forms of mental and emotional disturbance, as well as detailed knowledge of the results of effectiveness research and of all the possible complications that drug treatment can entail.

Mental disorder as a set of social problems

We have been so indoctrinated into the idea that mental disorders are problems that are located in individuals, just like other medical conditions, it is sometimes difficult, even for the most critical of thinkers, to step outside this paradigm. Yet, mental disorders are not identified within an individual like diseases of the body. Mental disorders are problems of social groups or units. We too often think just of the individual's emotional state, whether they are depressed or anxious, for example, and not of what social expectations or obligations they are failing to fulfil that makes their emotional state problematic to them and to others. Similarly, when someone is diagnosed with schizophrenia, we focus upon their unusual beliefs, rather than looking at how these impact on their ability to get along in the world.

Historical scholarship, however, reveals how mental health problems are problems of communities. Modern psychiatric care and the legislative framework that surrounds it, emerged out of the mechanisms devised by local communities for maintaining social order and providing care for dependents. Before formal legal systems were introduced, early societies such as Anglo Saxon England, had informal ways of maintaining the safety and order of the community, dispensing justice and caring for those who were sick and incapacitated (Dershowitz, 1974). In England and Europe religious institutions played a role in providing care and sustenance for those who could not provide for themselves. With the dissolution of the monasteries under Henry VIII, a new state-sponsored system of social welfare was introduced in England called the Poor Laws. These laws, which were updated periodically over succeeding centuries, placed an obligation on local communities to care for their poor and needy and to help safeguard the safety of the community as a whole. Family members could apply to the Poor Law officials of their local area for food and clothes if the harvest failed, or if some other catastrophe meant they were unable to sustain themselves, including situations in which one of the family breadwinners became incapacitated due to a mental disorder. If the family were unable to look after the individual concerned, the Poor Law officials could make arrangements for other local people to provide care. If the safety of the community was threatened, the officials would also ensure the individual was placed somewhere safe and secure, sometimes, if no local solution could be found, involving transfer to the nearest prison (Rushton, 1988). Wealthier people made their own arrangements, since they could not call on the resources of the state.

For the next few centuries, the Poor Laws provided the framework within which people without their own assets were cared for if they could not provide for themselves. Although most people remained in their own homes, and received aid or welfare known as 'outdoor relief', institutions

such as Poor Houses and Workhouses, grew up to house those poor people who did not have homes, or who could not be supported within the family home. Michel Foucault and historians, such as Andrew Scull, have documented how the mental asylums and the practice of psychiatry emerged out of these institutions, providing supposedly specialist care for those who were too incapable or disruptive to be managed within the meanly-funded and brutally managed Victorian Workhouses (Foucault, 1965, Scull, 1993)(Foucault and Scull). The asylums continued the dual functions of the Poor Law system by providing care for those who could not provide for themselves, and safety for the community from individuals who were behaving in a threatening or disruptive manner, but were too mentally disturbed to be amenable to the dictates of the criminal law.

Modern mental health care

When we look at the history of psychiatric care in this way, we can see that the modern system fulfils the same social functions. Behind the façade of treating an individual's medical pathology, what the system provides is care for those who are not able to look after themselves, and containment and policing of those who present a threat to the peace or safety of the community, but whose behaviour cannot be addressed within the confines of the criminal law due to a lack of rationality or capacity.

Just as in pre-Victorian days, much of this system now operates outside the concrete institutions that exist to contain the most severely disturbed. The state spends considerable resources supporting people who are not able to provide for themselves in the form of sickness and disability payments for depression, anxiety and other 'common mental disorders'. The fact that these have increased, more rapidly than payments for other medical conditions, despite a huge increase in the availability of treatments, suggests not only that the treatments are ineffective, but that they miss the point (Viola & Moncrieff, 2016)(Viola and moncrieff). What the system is providing is money and care for those who are unable to provide for themselves either temporarily or permanently.

Similarly, the idea that people diagnosed with schizophrenia or 'bipolar disorder' have a disease provides the justification to lock them up against their will and forcibly change their behaviour with drugs, as if this process were as uncontroversial as treating pneumonia or lung cancer. Some individuals will later be thankful that measures were taken to contain their behaviour when they were 'not in their right mind'. But others never see the world quite as others see it, and for these people treatment means forcible modification of their behaviour in the interests of maintaining social peace, often on a life-long basis.

The current system, built as it is upon the 'myth of mental illness,' that is the unsubstantiated claim that mental disorder is just like any other medical condition, serves the useful function of keeping potentially controversial issues out of the public arena. Just as the rate payers of old complained that hoards of 'undeserving' poor took advantage of the benefits provided by the Poor Laws, people nowadays might begrudge their hard earned taxes being paid to those who appear to be physically capable of earning a living. The state, too, occasionally becomes alarmed at the extent of welfare costs, and makes tentative efforts to reign in disability spending from time to time, but it cannot afford to dispose of the system altogether. Sickness and disability benefits in the western world are overwhelmingly paid to those in manual social classes for whom decently paid, reliable work has disappeared over the last few decades. They are the price that western capitalism pays for the outsourcing of unskilled jobs and heavy industry to the developing world where labour is cheaper. This process has left devastated communities in its wake, rife with the demoralisation and insecurity

that is labelled as depression and anxiety, so that individuals can be emotionally subdued using chemical suppressants, and any challenge to the system as a whole is stifled before it is even born.

The future: an alternative understanding of mental disturbance

The future of psychiatry is thus intimately entwined with the future of society as a whole. As long as society needs a myth to keep the peace and manage disorder and discontent, then a system that fosters the idea that mental illness is a brain disease and that treatment is a sophisticated medical process will continue to flourish. People may benefit from the financial support the current system offers in the absence of opportunities for more fulfilling ways of living, but they may be harmed too by the implication that they are biologically flawed, chronically impaired, that their problems are beyond their control and that toxic chemicals represent a simple and benign solution.

Accepting that mental disorder is not a disease, but simply how some people are or come to be, did not used to be a particularly radical idea. Adolf Meyer, the leading American psychiatrist of the mid 20th century suggested that what we refer to as mental illness could be thought of as ways in which some people respond to the world around them and the challenges it can pose (Meyer, 1948). Some ways of reacting to the world may be, or appear by conventional standards to be, self-defeating, but they can still be genuine and meaningful. Meyer reflected the influence of psychoanalysis, but thinkers and practitioners from many other traditions have also described mental disorder as a meaningful response to life's challenges, or simply as 'ways of being human' (Jenner *et al.*, 1993)(REF) that are not fundamentally different from ordinary, more familiar forms of behaviour.

If we understand mental disorder in this way, how should we, as a society, respond? How are we to help people whose behaviour causes themselves distress, and how should society react to people whose behaviour causes harm or inconvenience to other people? What role, if any, should psychiatrists have in an alternative system?

Helping people to change

First, if we understand mental distress as a reaction to life circumstances, then the first question we must ask is what is it about our current society that drives so many people to feel anxious or unhappy or that they cannot manage the demands that are made of them? Mental disorder can often be usefully seen as a 'signal to change', an indication that something is wrong, either with the nature of society as a whole, or with an individual's current way of life. Insecure employment, inequality of wealth, lack of meaningful opportunities for communal engagement all take a toll on people's emotional well-being. People in more advantaged situations may still be under immense pressure to perform and compete, to work long hours and to sacrifice time they could spend in more personally fulfilling activities. The solution to much current mental distress is not the tweaking of individual brain chemistry or cognitive inclinations, but political pressure to create a society that provides accessible opportunities for everyone to lead secure and rewarding lives.

Sometimes, however, an individual's reactions and behaviour seem to be part of the problem. There are many ways that people can be helped to change. Traditionally people turned to family, friends, colleagues or religious leaders for guidance about how to conduct themselves and how to address obstacles and challenges in life. More recently, people have looked to professionals including therapists and councillors. Mind-altering drugs are another enduringly popular technique for changing one's mental state and behaviour. For millennia people have used drugs like alcohol and

opium to dull grief, worry and sadness. Yet, it is far from obvious that drugs are useful in this sort of situation when consumed on a long-term basis.

Many of us have had a drink once or twice when we have had a shock or are trying to deal with a crisis in our lives, and we may well have found that the intoxication it produced brought temporary relief from our worries. Few people would think that long-term drinking is a sensible solution to any emotional or personal problem, however. Indeed, we only have to look at people who have problems with addiction to drugs like alcohol or heroin to see how using drugs to combat personal difficulties can become a problem in itself. Being under the influence of a substance that numbs emotions and dulls pain and anxiety makes people less likely to learn other techniques for managing emotions and getting by in the world, and prevents people from addressing underlying problems. Under the influence of something that diminishes one's sensitivity and reactions, people may be able to cope more easily with boredom and frustration and tolerate difficult, unrewarding or even abusive relationships.

There is no doubt from dozens of advertisements from the 1950s and 60s that drugs like the benzodiazepines were widely prescribed to mute people's discontent, especially women's.

But modern antidepressants like Prozac are presented in a completely different way. They are presented as a disease-targeting treatment, something that works by rectifying an underlying chemical imbalance, not by putting people into a mild state of drug-induced stupor. This way of promoting antidepressants has concealed their mind-altering properties. Although most SSRIs have

only weak psychoactive effects, they do seem to induce a subtle state of emotional detachment or numbing (Goldsmith & Moncrieff, 2011). People speak of finding it difficult to cry, for example, and not being able to feel particularly sad or happy. Therefore it seems that, although less blatant than their predecessors, modern antidepressants may also help people accommodate to adverse circumstances that they might not otherwise tolerate. Although data from randomised controlled trials does not convincingly demonstrate that antidepressants are any better than placebo (Moncrieff, 2018), these effects may theoretically provide some short-term relief. However, this sort of suppression of feelings and reactions seems unlikely to help people to deal with life challenges effectively in the long run, and may help to perpetuate situations which are making people unhappy in the first place.

Today, psychiatrists meet many people who are struggling with difficult circumstances such as divorce, unemployment, debt or the feeling of lacking meaning and direction in life. Psychiatrists, like other professionals, can help people to weigh up the pros and cons of using different strategies to address their particular difficulties, including considering the use of mind-altering drugs. First, however, they must disabuse people of the idea that they have a brain disorder that requires a drug to put it right. Then they can start a conversation about what the individual's problems actually are and how these can be most effectively solved or managed. They can discuss honestly with people the possibility of using mind-altering substances to alter and suppress emotional reactions, acknowledging the limited evidence that this strategy is helpful, the risks that it entails and sharing our accumulating knowledge of other people's experiences.

Forcing people to change

What about those people whose behaviour is more severely disturbed, or disturbing to others? Sedative drugs of any sort are likely to quieten down agitated or aggressive behaviour and, in my experience, antipsychotic drugs can help diminish people's preoccupation and emotional investment in psychotic experiences. Sometimes this enables people to engage in other activities again, to look outward in a way they were unable to while psychotic. We should be mindful, however, that the way this effect is achieved is at the cost of dampening down people's interest and motivation as a whole, and that, quite apart from the serious physical complications of long-term antipsychotic treatment, this is a high price to pay for relative normality. As antipsychotic user, Peter Wescott wrote in the *British Medical Journal*, 'in losing my periods of madness I have had to pay with my soul' (Wescott, 1979).

We need to acknowledge that treating people with mental disorder is behaviour modification, not medical treatment. We are giving people drugs to change their state of mind and the behaviour that is manifested in, not to cure an underlying disease or biological abnormality. If this is done against the individual's wishes, this is an exceptional situation that requires strong safeguards and ongoing scrutiny to ensure that it is properly justified.

We need to be quite sure, therefore, that forced treatment is completely necessary and that no alternatives are possible. Yet we know that some people can recover from psychosis naturally, without drugs and have a good long-term prognosis (Bola & Mosher, 2003, Wunderink *et al.*, 2013). Non-intrusive social support and activities to maintain some engagement with the world would seem to be helpful in this situation, although we need more research in this area (Cooper *et al.*, 2019). We need to have facilities, therefore, that enable people to be treated without antipsychotics, if this is what they want, and to wean off antipsychotics after recovery where these

have been used. This is not a Utopian dream - in 2015 Norway passed a law that mandated the introduction of such facilities (Whitaker, 2017). Although they may be expensive in the short-term, the costs of maintaining people who are permanently impaired by the effects of antipsychotics are likely to offset this in the long-run, even if it is only a small proportion of people who can be helped to avoid long-term drug treatment.

Where people remain acutely psychotic for long periods, then I think antipsychotic treatment should be tried, sometimes even if this is against the individual's wishes. This decision should not be a medical decision, however. Over-riding someone's wishes in this way should be a legal decision, where evidence of the benefits and harms for the individual, their family and society is all weighed in the balance. It must also be subject to ongoing legal scrutiny.

The use of potentially harmful drugs requires personnel that have some medical and pharmacological expertise, so psychiatrists can play a role in this scenario. Again, however, what is important is an acknowledgement of the actual nature of the activity; that 'treatment' in this case involves forcible modification of behaviour, often principally in the interests of other people rather than the individual, which is ultimately a socially-driven activity and not a medical one.

Whether such changes in our approach to mental disorder will come about depends on whether society is willing to confront the complexity of addressing the huge variety of social difficulties that we currently bundle under the label of mental disorder in a more transparent way, or whether it prefers to keep sweeping it under the medical table. In the meantime, critical psychiatrists can only continue the difficult task of trying to have an honest dialogue with patients within a framework of understanding that has been constructed to disguise the truth.

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