Correspondence

The correct paradigm may be that of evolutionary psychiatry

Dr Thomas Szasz repeats his view that psychiatric illness does not exist, and that people should be held responsible for their beliefs and actions.[1] But what if we are presented with a mother who believes she has committed an unforgivable sin, and that she and her baby are infested with the devil, with the only solution being to kill herself and her child? We know that with treatment, or just with the passage of time, she will return to normal and realise that her 'sinfulness' was delusional. As I understand Dr Szasz, he would consider treating her to be 'a grave violation of her basic human rights' and he would advise us to let her 'minister to herself'. Yet does she not have a basic human right to be treated, even if she has no insight into her need for treatment?

It is likely that evolution has prepared mental states for extreme situations and that it is possible to enter one either because a person is in an extreme situation, or by mistake, on the 'smoke detector' principle that it is better to be frightened to death a hundred times thinking there is a lion in the bush rather than ignore one real clue that a lion really is there.[2] It may be impossible to tell whether a mental state is caused by a real danger or disaster, or is due to a psychic mistake. A depressed mother with a baby may be a member of one of those societies who try to maintain a constant population, whose surplus men go into monasteries and only one daughter per family is allowed to breed, and she may have offended against society's rules by getting pregnant outside marriage. In the *Book of Job*, Job lost his children and all his cattle and became depressed, but why did his so-called comforters not offer their condolences on the death of his children? This may suggest that the text can be as easily read as a story of a man who, owing to psychotic depression, had the delusion of loss of property and death of loved ones.[3] In psychiatric practice we are often dealing with people who have entered states of depression and anxiety when there is no real cause – are we not to help them?

The paradigm here is evolutionary psychiatry.[4] It is not necessary to view these deluded and anxious people as either sinful or responsible – whether or not we treat them as 'sick' depends on factors such as eligibility for NHS healthcare and other practical matters. We have been fashioned by evolution to suffer inappropriate extremes of mental pain and delusional ideas – it is more important to help these people back to normality than to spend time discussing whether they are sick or bad or should bear responsibility for themselves.

I must acknowledge one debt to Dr Szasz. In my long career in working age psychiatry, I was often asked by troubled patients what to say when, applying for a job, they were asked whether they had ever had mental illness. Knowing of the stigma and prejudice that a positive answer would probably arouse, I was able to say to them with a clear conscience, 'Think Szasz and say 'No!'.'

1 Szasz T. The myth of mental illness: 50 years later. *Psychiatrist* 2011; **35**: 179–82.

2 Nesse RM. Natural selection and the regulation of defences: a signal detection analysis of the smoke detector principle. *Evol Hum Behav* 2005; **26**: 88–105.

3 Price JS, Gardner Jr R. Does submission to a deity relieve depression? Illustrations from the Book of Job and the Bhagavad Gita. *Philosophical Paper Rev* 2009; **1**: 017–31.

4 Bruene M. *Textbook of Evolutionary Psychiatry: The Origins of Psychopathology*. Oxford University Press, 2008.

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Just the facts, please

Edward Shorter's riposte to 'The myth of mental illness' cuts through the redundant reasoning of Szasz, in some style.[1,2] Shorter succeeds by contrasting the notions of mental illness in the 1960s with modern science of the brain. In doing so, he also highlights the progression of psychiatry during this period. Unfortunately, his argument is undermined by unscientific claims. How many suicides resulted from anti-psychiatry? How many are due to *One Flew Over the Cuckoo's Nest*? Shorter says 'many'. If this is based on evidence, a reference should be cited. If not, why include conjecture in an otherwise excellent commentary?

1 Shorter E. Still tilting at windmills: Commentary on . . . The myth of mental illness. *Psychiatrist* 2011; **35**: 183–4.

2 Szasz T. The myth of mental illness: 50 years later. *Psychiatrist* 2011; **35**: 179–82.

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Ill-mannered and ill-informed

It is astonishing to read in *The Psychiatrist* the coarse, ignorant and abusive screed by Edward Shorter as a commentary on the 50th anniversary of Szasz's scholarly book, *The Myth of Mental Illness*.

The book contains 'bombast', Shorter declares, and 'cock-eyed belligerence.' Portentously, Shorter explains that: 'in the way of its fraudulent notions', and those of the movie *One Flew Over The Cuckoo's Nest*, along with the anti-psychiatrist writings of Foucault, Laing and Cooper (who actually were quite unconnected with Szasz, his book, and the film) people decided not to seek psychiatric help and 'many died by suicide' instead for which the 'anti-psychiatry gurus' were therefore responsible.

Shorter cites no published evidence for this demonising of Szasz and the anti-psychiatrists and in fact there is none to cite. If this were not enough, Shorter goes on to make pronouncements about psychoanalysis, which he declares is dead. Does he mean dead in Toronto where he lives, or

worldwide? Either way his pronouncement is nonsense I am personally acquainted with psychiatrists in academe in Toronto who are very much involved with and practise psychoanalysis. Also, I live in Italy, where psychoanalysis is alive and well as ever.

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Whistling in the wind

There are reasons to be critical of Thomas Szasz's views about mental illness. For example, few would want to go as far as him in recommending that society manage without a mental health act. His definition of illness as physical lesion also unnecessarily excludes psychological dysfunction as illness.

In his commentary,[1] Edward Shorter focuses on criticising Szasz on an issue on which he is in fact correct, namely that no biological markers have been found for mental illness. Shorter seems to be using his skills as a historian to suggest that psychiatry has overlooked what he calls obvious evidence of organicity from past research in the role of panicogens in triggering panic disorder; the response of catatonia to barbiturates and benzodiazepines; and hypothalamic–pituitary–adrenal dysregulation in melancholic depression (see my Critical Psychiatry blog entry on 16 May, http://criticalpsychiatry.blogspot.com). The general conclusion from this research, unlike that of Shorter, is that no biological cause of mental illness has been found. Even the American Psychiatric Association admit that 'brain science has not advanced to the point where scientists or clinicians can point to readily discernible pathologic lesions or genetic abnormalities that in and of themselves serve as reliable or predictive biomarkers of a given mental disorder or mental disorders as a group'.[2]

Szasz has been dismissed as an anti-psychiatrist. Even 50 years later, the point of his 'myth of mental illness' has not been understood. Shorter's unscientific attack on Szasz does not promote the interests of psychiatry.

1 Shorter E. Still tilting at windmills: Commentary on . . . The myth of mental illness. *Psychiatrist* 2011; **35**: 183–4.

2 American Psychiatric Association. *American Psychiatric Association Statement on Diagnosis and Treatment of Mental Disorders*. Release no 03-39, September 25, 2003 (http://www.psych.org/MainMenu/Newsroom/NewsReleases/2003NewsReleases/mentaldisorders0339.aspx).

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Battling the wrong enemy!

Dr Shorter's *ad hominem* attack on Professor Szasz provides no convincing argument against Szasz's well-known position concerning what he regards as the spurious medicalisation of mental illness. Nor will there be wide agreement with Shorter that neuroscientific studies suggesting a 'neurological basis for much psychiatric illness' negate Szasz's firmly held beliefs.

It is regrettable that Dr Shorter missed the opportunity to remind our colleagues that the rampant misuse of psychiatry 50 years ago as described by Szasz is applicable to the way institutional psychiatry is practised today in many parts of the USA, Canada and the UK, and certainly in most of the other countries in the world.

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Another view of mental health tribunals

Dr Choong writes of his perception that the number of Mental Health Act Section 2 detentions is rising, and refers to 'an uncritical approach to using guidance that results in Section 2 being used much more frequently now' and the 'waste of time and resources in dealing with the inevitable extra tribunals'.[1]

His perception mirrors the national picture. From 1998/9 to 2008/9, total uses of Section 2 in National Health Service (NHS) hospitals in England went from 20 874 to 23 482[2] and the numbers continue to rise (25 622 in 2009/10).[3] Total use of Section 3 dropped slightly for the period 1998/9 to 2008/9,[2] from 22 738 to 21 538. There was a corresponding increase in conversions from Section 2 to Section 3 (4048 to 5145).[2] Data have to be examined carefully as figures may be given for England alone or England and Wales, give NHS and independent hospital figures either separately or together, and refer to total uses or admissions. Data usually refer to instances of detention, not the number of different individuals detained.

As to mental health tribunals being a waste of time and resources, I think there is room for another view. In 2007/2008, 21 849 applications were received, of which 10 380 were withdrawn before the hearing and 9137 were heard (3157 outstanding at year end); of those that were heard, 17% resulted in the section being discharged, which means over 1550 patients.[4] It is not possible to say in how many cases the responsible clinician discharged the section in advance of the hearing because the impending hearing focused his or her attention on the question of whether continued detention was justifiable, but if this was the case in even 10% of those cases, this would amount to over 1000 patients being released from detention of doubtful legality because of a forthcoming tribunal.

If patients are first placed on Section 2 and then converted to Section 3, they will be entitled to two tribunal hearings within the first few months of detention, rather than the one they would have if Section 3 were used initially. Moreover, the first tribunal would occur within weeks of admission, instead of up to several months later. Given the substantial number of detentions that are ended by tribunals, the decision to use Section 3 rather than Section 2 initially would appear to result in a large number of people being detained on doubtful grounds for longer than necessary.

Statistics on mangers' panels are not published, so it is much more difficult to make a comparable argument about their usefulness based on objective information about their decisions.

As a clinician, I believe that the discipline of having to prepare for mental health tribunals by thinking through the reasons why my patients should be detained often leads to