

**Plus ça change**

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Shortly after my book *Depression: The Way Out of Your Prison* was published in 1984, Angela Tilby, now the Reverend Angela Tilby but then a BBC TV producer working on the *Everyman* series, made a programme about my book called *The Mind Box* (Rowe ). This programme attracted nearly 2 million viewers, and afterwards it seemed that every one of these viewers wrote to me. This may be an exaggeration, but it is not an exaggeration to say that the majority of those who wrote said, "I've asked my GP if he'd refer me to someone I could talk to but he said not to be silly, just keep taking the tablets".

These GPs were not being obtuse and difficult. They were simply following the advice given by the Royal College of Psychiatrists who saw depression as a physical illness caused by a chemical imbalance in the brain, underlying which was the gene for depression. Consequently the appropriate treatment was antidepressants and electroconvulsive therapy.

In 2006 the Royal College of Psychiatrists abandoned the idea of chemical imbalance. The College now advises doctors that antidepressants (and, rarely, ECT) should be used only with severe depression, while in all levels of depressions, mild, moderate and severe, psychotherapy is the appropriate treatment.

What has brought about this change? Psychiatrists have known all along that there was no scientific evidence for a chemical imbalance in depression, and that nothing remotely like a depression gene had ever been found. They regarded the idea of a chemical imbalance as a hypothesis which validated their way of working as doctors dealing with people with a mental illness. In 2006 they changed their ideas about depression. This change appears to be significant, but appearances can deceive.

When Kraepelin identified the mental illnesses of depression and schizophrenia he described them as being lifelong conditions. When in 1968 I arrived to work in the clinic attached to the Department of Psychiatry at Sheffield University my psychiatrist colleagues were revising their definition of depression. The advent of the first antidepressants meant that many patients seemed to get better. Perhaps depression was not a lifelong illness. Many of these patients became depressed again, but this was seen, not as a failure of the drugs to cure, but as evidence of a permanent underlying condition from which the drugs gave periods of remission. This was but a slight modification of ideas, not a change.

However, the old order of the psychiatric system was beginning to crumble. Some enlightened administrators and psychiatrists were concerned about the run-down state of the asylums, not just the buildings but the stagnant system itself. In 1971, when I had finished my PhD and was looking for a job, I was appointed to a post by an administrator who hoped that a few psychologists might be the wedge he was trying to drive into a local psychiatric system which was highly resistant to change. I had done my PhD in a university department of

psychiatry where I had found that the psychiatrists I worked with had no idea what psychologists did other than to give intelligence tests. Naively believing that my role as psychologist was to offer alternative hypotheses for the phenomena we were examining, i.e. the behaviour of our patients, I committed the greatest heresy of challenging the ideas held by the consultant psychiatrists. Moreover, I took a completely unnecessary interest in the life histories and the relationships within the families of our patients. These life histories and relationships were invariably sad, even tragic, and revealed so much loss, cruelty, betrayal, enmity and neglect that it seemed to me that to explain the patient's behaviour in terms of some unknown physical cause was a reprehensible neglect of the principle of Occam's razor, which requires that nothing unnecessary or tangential should be included in an hypothesis.

An influx of new ideas always leads people to question the old ideas, even those ideas which were regarded as absolute truths. The 1970s was a decade of new ideas about what it was to be a person. These new ideas penetrated even the closed worlds of the two asylums where I worked. In our psychology department we ran many workshops on the new kinds of talking therapy. Social workers, occupational therapists, nurses came, but not one psychiatrist. Meanwhile, across the country, people were discovering that, if there was no expert who could solve their particular problem, they could get together with others with the same problem and help themselves. Many depressed people found that their self-help group effected a cure, the like of which psychiatrists and drugs had never done.

One group called itself "Survivors of the Psychiatric System", and went on to create more changes in the thinking about mental illness than any of the professionals achieved in the following years. "Survivors" demanded that the account they could give of themselves and their lives should be taken seriously by the professionals and not dismissed as being no more than evidence of a mental illness. In 1976 MIND stood at the crossroads. Was it going to become an establishment charity as SANE did some years later, or would it not just represent but work with the very people it was set up to help? There was a battle, but the "Survivors" won. Their role in MIND led to "Survivors" working as advocates for patients who could not represent themselves, and to being given places on advisory teams, even within the Royal College of Psychiatrists. In the advice, which is now given to psychiatric staff, much is made of treating patients with respect. Psychiatric patients might no longer be despised and neglected as they were in the old asylums but now they have to endure being patronised, usually in terms of, "I feel so privileged that you've shared that with me". Would we say this to a friend who had confided in us?

In the early 1980s the Thatcher government decided to turn a health service into a business. Consultants saw their power being taken over by managers. Some consultant psychiatrists resisted losing their supreme power but others saw an advantage in appearing to share responsibility with a multi-disciplinary team. Many of the younger psychiatrists were enthused by what they learned from psychologists and social workers. However, the turmoil caused by the various governments' continual reform has often negated whatever beneficial changes there were.

The 1990s marked thirty years since the invention of the first antidepressants. The creation of antibiotics had meant that common infectious diseases like typhoid and diphtheria disappeared, but depression did not disappear. Statistics seemed to suggest that it was increasing. Moreover, long term studies were showing that people treated only with antidepressants were unlikely to recover. Each episode of depression was a predictor of yet another episode. Some people might conclude from this that the antidepressants were not working, but, in a swift act of hypothesis saving, psychiatrists decided that there is a form of depression which they called chronic depression. Patients who appeared to be well should continue to take antidepressants in order to ward off the chronic form of the disease. Unfortunately, the prophylactic use of antidepressants was found not to work. Psychiatrists returned to Kraepelin's view that depression was a lifelong mental illness. Depression needed to be managed in the way that diseases like diabetes and epilepsy are managed. Psychiatrists could no longer take refuge in the belief that there was a depression gene. Geneticists kept telling them that a single gene could not account for any complex behaviour. Even worse, research results seemed to suggest that the talking therapies could effect some kind of cure. Perhaps the greatest blow followed from the day that Patsy Hage ceased to be a grateful patient and told her psychiatrist Marius Romme that he should ask her what her voices actually said to her. It was patients, not professionals, who showed that auditory hallucinations are not symptoms of an illness but meaningful experiences. It was survivors, not professionals, who developed the techniques for living with such experiences.

At the same time many survivors were demonstrating that it was possible to recover from schizophrenia and go on to live an ordinary life. Out of this came a survivor-led movement called Recovery. In an effort to reclaim the ground they had lost, many psychiatrists and psychologists made the word "recovery" their own and now use it when what they actually mean is "manage your illness". Similarly, many psychiatrists and psychologists now claim to be the experts on the diagnosis and treatment of auditory hallucinations.

By the beginning of this century it was clear that, whatever depression was, it had a markedly deleterious effect on the economy. Something had to be done. Some people might feel that, as psychiatrists had not solved the problem of mental illness, they should bow out and let another group see what they could do. Such people overlook the fact that the profession of psychiatry enjoys power, status and privilege, and throughout history no group has ever voluntarily given up power, status and privilege. It takes the ballot box, if not the AK-47, to achieve that. When different groups battle for power, status and privilege, it can be difficult to see the ideas which underlie such a battle. Yet it is a battle over whose ideas shall prevail. In the field of mental health these ideas are many and various, but there are two ideas on which all the other ideas depend. These are the ideas of what constitutes a person.

All the theories which psychiatrists and psychologists have devised can be grouped according to the particular idea of a person on which the theory is based. Is the person a puppet or an agent?

A puppet behaves according to which of his strings is pulled. These strings might be mental illnesses, or traits, or instincts, or society, class, nationality, religion, or

planets. An agent is an autonomous person who assesses, decides and acts. Puppet theories might seem to demean the person but they have two delicious advantages. A puppet theory allows for an expert, someone who knows more about the puppet than the puppet can ever know. Moreover, a puppet can never be responsible for what he does. A puppet can claim that whatever he did was the fault of his illness, his traits, his instincts or his star sign. Agent theories have two great disadvantages. An agent is always responsible for his actions, and no one other than the agent can be the expert. An agent always knows more about himself than anyone else can know. Professionals who use the agent model of the person know that they cannot cure their client nor advise him about the best way to live his life. Their task is to help their client explore and clarify his ideas and to examine alternative constructions and their possible outcomes. There is little power, status and privilege attached to their role.

It might be some comfort to those who espouse the agent model to know that neuroscientists have shown that the agent model best represents the way human beings behave. The research which shows this is vast and detailed, but a number of the scientists involved in this research have written excellent books for the general public. Two of these are Antonio Damasio, Professor of Neurology at the University of Iowa, and Dennis Noble, Emeritus Professor of Cardiovascular Physiology at the University of Oxford.

Antonio Damasio writes about images which he defines as, “mental patterns with a structure built with the tokens of each of the sensory modalities – visual, auditory, olfactory, gustatory, and somatosensory [which] includes varied forms of sense: touch, muscular, temperature, pain, visceral, and vestibular. . . The word also refers to sound images. . . . Not all the images the brain constructs are made conscious. . . When you and I look at an object outside ourselves, we form comparable images in our respective brains. . . But this does not mean that the image we see is a copy of whatever the outside object is like. Whatever it is like, in absolute terms, we do not know. . . The brain is a creative system. Rather than mirroring the environment around it, as an engineered information-processing device would, each brain constructs maps of the environment using its own parameters and internal design, and thus creates a world unique to the class of brains comparably designed” (Damasio 2000 p 318 – 321, 337). In other words, each of us sees the world in our own individual way.

Antonio Damasio sees the mind as a process, not as a thing. Dennis Noble sees the self “as an integrative construct, occasionally a fragile one. It is also a necessary construct. It is one of the greatest symphonies of the music of life” (Noble 2006). In his book *The Music of Life*<sup>i</sup> he shows how Richard Dawkins’ description of the selfish gene can be read as an example of the puppet model or as an example of the agent model. Noble writes, “Genes, like the digital information on a CD, are “only” bits of a database, they do not deterministically “program” anything on their own, and it is organisms that live or die and so provide the basis for evolutionary selection. . . A gene can do nothing without this interpretation by the system” (Noble 2006). For both Noble and Damasio, the agent model is the one which best fits what is known of how human beings operate.

A naïve observer might think that what neuroscientists have found would be of immense importance to all psychiatrists and psychologists. It provides an explanation of why people behave as they do. This could be stated as, “What determines our behaviour isn’t what happens to us, but how we interpret what happens to us.” These interpretations are constructions created by the brain out of the person’s past experiences, and, as they are constructions, the person is free to change them. A naïve observer encountering CBT might think that this form of therapy is based on this explanation of behaviour. Yet, when Raj Persaud interviewed Dr Ben Wright, head of the Newham Psychological Treatment Centre, Dr Wright said, “What we think affects the way we feel and how we function in the world” (All in the Mind BBC Radio 4, May 1, 2007).

Such a use of “affects” implies that other things are of importance in how we feel and function. It ignores the fact that we interpret all these other things, and that these interpretations are part of what we think. For instance, we might live in poverty, but we can interpret our situation as being one to which we must be resigned, or one that shows that our suffering will be rewarded in heaven, or one which justifies our criminal behaviour, or one that provokes us to rebel. However, Dr Wright was following the example of his professional college. The website of the Royal College of Psychiatrists carries a fact sheet about depression which lists the factors involved in the causation of depression (<http://www.rcpsych.ac.uk/>). These are: things that happen in our lives; circumstances; physical illness; personality (“This may be because of our genes, because of experiences in our early life, or both”); alcohol; gender (“Women seem to get depressed more than men do. It may be that men are less likely to admit their feelings and bottle them up, or express them in aggression or through drinking heavily. Women are likely to have the double stress of having to work and look after children”); and genes (depression can run in families). No mention is made of how different individuals interpret each of these factors in different ways.

Psychiatrists may have abandoned the model of the puppet manipulated by chemical imbalances but they have replaced it with the model of a puppet manipulated by seven factors about which they, the psychiatrists, are the experts. As Talleyrand, that great master of political survival, said, “Plus ça change, plus c’est la même chose”.

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