CHAPTER 1

Introduction

Mental illness is a mystery. That is why I chose psychiatry as a career, and why I love it. It is still a pioneer field, and answers to the most important questions about mental illness will probably require another century of research. But becoming a psychiatrist was one of the best decisions I ever made. Fifty years later, I have no interest in retirement.

As I grow older, I have become interested in the history of my specialty. As a medical student, I did not understand why we were taught the history of medicine. Once ideas go out of date, why learn them? Now I have come to realise that progress is not linear. Impeded by false beliefs, medical science sometimes goes off on serious tangents. Understanding past mistakes helps us to be appropriately sceptical about current theories and practices.

I have always been the type of person who questions everything. When I was young, this trait got me into trouble. Teachers saw me as a rebellious young man, but I had a strong need to question all received wisdoms. Now, in my old age, I am called a curmudgeon for saying some of the same things. Although psychiatrists do a lot of good for patients, it is important to criticise contemporary practice, especially its susceptibility to fallacies and its penchant for fads. That is the passion that drives this book.

The title is a deliberate paraphrase of a classic volume by Martin Gardner (1957), *Fads and Fallacies in the Name of Science*. Fads are temporary bursts of enthusiasm, based on fallacies that reflect cognitive errors or wishful thinking. When we think of fads, bizarre ideas come to mind, and Gardner's book focused on very strange theories. But fads in psychiatry have occurred not only on the fringe, but in the very mainstream of theory and practice. Some of the trendiest theoretical paradigms may turn out to be unsupported by data. In diagnosis, the many faddish approaches to classification are unlikely to last. In treatment, both psychopharmacology and psychotherapy sometimes embrace interventions with a weak base in evidence that run the risk of doing harm to patients.

This is not to say that psychiatry consists of nothing but fads and fallacies – far from it! In spite of enormous gaps in knowledge, we do at least as well as physicians in other specialties in helping our patients. The problem is

that psychiatry does not fully understand mental disorders, the causes of which remain as obscure as ever.

Should we be surprised? No. The brain is the most complicated structure in the entire universe. Neuroscience will not solve these problems quickly. We are told that answers are just around the corner, but that is where they tend to stay. The most important questions in psychiatry remain unanswered.

Since psychiatrists have so much to learn, they should remain humble. The current rage to reduce everything in psychiatry to a neuronal level is an idea that has some degree of merit, but it is oversimplistic and hubristic. Neural processes can only be understood in the context of interactions with psychological adversities and sociocultural stressors. Although multivariate models are complex, they explain why research on the origins of mental illness and their treatment is so difficult.

Ironically, the main source of psychiatric fads is that practitioners want so badly to help their patients. Human nature being what it is, clinicians are uncomfortable with doubt and seek certainty. They have trouble maintaining a cautious stance in the face of scientific ignorance. Practitioners do not want to wait a hundred years for answers, and are tempted to believe they know enough already. That is the main reason why psychiatry has been infected by fads and fallacies. This book will document how and why this happens.

Why I have written this book

I began my career as a clinician and an educator. In spite of doubts, I largely accepted the point of view my teachers had given me. With time, I came to realise the older generation was wrong about many things. I became committed to a scientific perspective, and trained myself to become a researcher. I became a passionate convert to evidence-based medicine. I no longer took clinical experience, even my own, for granted. For this reason, I have taken care to ensure that most ideas in this book are at least consistent with the empirical literature, and refer the reader either to relevant studies or to comprehensive reviews. However, since the subject is so vast (psychiatry as a whole), I have had to be very selective about references.

This book will also draw on my 40 years of work as a consultant. Describing these clinical encounters is not intended to contradict one of the main themes of this book, which is that one cannot base practice on clinical experience. I will use consultations to illustrate points that can be confirmed by empirical data. Since 1972, I have been in charge of a hospital clinic that sees hundreds of patients every year referred from primary care. I also worked in a university health service for 25 years, and after setting up a specialty clinic for personality disorders in 2001, conducted thousands of consultations on patients with these conditions. Although I still treat sicker patients in specialised clinics, like many of my colleagues, I spend more time than I did in the past on consultations to primary care.

In total, I estimate that I have seen 25 000 patients over the past 40 years. When my students ask me how I seem to understand problems and make diagnoses rapidly, I tell them that things get easier after the first 25 000 cases. But even the most extensive experience does not make you right. You could be making the same mistakes thousands of times. That is why I so strongly support evidence-based psychiatry.

If you want to practise scientific medicine, you have to give up certainty and embrace doubt. In the first 10 years of my career, I aimed for radical changes in my patients. With experience, I learned that although I could help many people, psychiatry lacks the tools to achieve consistent and stable remissions of many mental disorders. The field is only beginning a very long journey. And since the specialty still has a relatively thin knowledge base, I went into research to do my part in broadening it.

My second career in research started quite late, in my 40s, so I could not reach the same level as others who started earlier, and I am only one soldier in a vast army. But I benefited from clinical experiences that some of my colleagues, tied to their labs and desks, lacked. Being an active clinician helped me to ask more relevant questions. In turn, conducting research affected my practice. The doubt that characterises the scientific culture is the best antidote to fads. I brought its world view back to my clinical work and my teaching.

The clinical trenches are far from the ivory tower of academia. Although I aim to practise, as much as possible, in an evidence-based way, some of the most crucial questions cannot be answered by empirical data. Thus, when I treat patients, I keep in mind what I can and cannot do. And even though I teach students to follow the research literature, I advise them to remain cautious about generalising from one or a few published studies. Unfortunately, not all my colleagues share this perspective. Some jump on bandwagons and pretend unjustified certainty. Most simply follow the crowd, and join in a consensus, however uncertain, if it is shared by their colleagues.

Psychiatric fads, then and now

When I was young, two theoretical models shaped psychiatry, and both became sources of orthodoxy. One was the psychoanalytic model. I began training in the late 1960s, during the heyday of psychoanalysis in the USA and Canada. At many universities, including my own, analysts were leaders in academic psychiatry. Trainees revered them. That was because they had an answer for everything. Analysts may have been arrogant, but students were attracted to their confidence and certainty. These were teachers who could provide plausible (or not so plausible) explanations for symptoms of all kinds. They also insisted, without evidence, that their treatment method was highly effective. When analysis did not work that was only because it had not lasted long enough, or was not conducted with sufficient skill.

The psychoanalytic fad was never as powerful in Europe. It had some influence in the UK, but never dominated psychiatry there. Disinterest in research ultimately proved to be its downfall. Neither the theory nor the method could stand up to empirical scrutiny. Today, although the analytic movement remains alive, it plays a marginal role in psychiatry, both in the USA and in Europe.

Although psychoanalysis was a fad, one cannot say that it was *only* a fad. Many of its concepts and methods have been incorporated into other forms of psychotherapy that have undergone clinical testing and have been shown to be effective. Research supports brief courses of psychoanalytic psychotherapy, and cognitive–behavioural therapy (CBT) makes use of some aspects of the same theory. Also, my ability to listen empathically to patients and to understand what they might be thinking comes from having been trained in this model. (It is also a skill that cannot be entirely turned off, even in private life.)

Following the rejection of psychoanalysis, modern psychiatry returned to its medical roots. Even in my student days, biological psychiatry had become an alternative orthodoxy. But psychiatry did not yet take psychopharmacology to an extreme. Although drugs are often effective, clinicians today may only treat symptoms in this way, losing interest in people and their life histories. That is why I expect and hope that psychotherapy will eventually make a comeback.

The 1960s was the golden age of psychopharmacology. The dramatic success of treatment for severe mental disorders gave biological psychiatry an enormous boost. Healy (2002) has described the medical management of psychosis as one of the most inspiring developments in human history. I entirely agree. I visited mental hospitals as an undergraduate student, and saw what patients with psychosis were like before drugs to control their symptoms were discovered. Yet only a few years later psychiatrists had highly effective treatments for most of them. I saw such patients discharged and maintained in the community after years of serious illness. This was indeed a time of miracles.

Biological psychiatrists were less colourful than psychoanalysts, but they kept psychiatry within the scientific mainstream. Instead of tradition and authority, they relied on research studies and clinical trials. Yet although neuroscience became the dominant force in psychiatry, it did not really explain why psychiatric drugs are effective (Healy, 2002). Moreover, the neuroscience community took a very narrowly biological approach, assuming that mental disorders are 'nothing but' brain disorders. That is both true and untrue. There can be no mind without brain, but psychiatry needs to study mind on its own level. Moreover, neuroscience should not ignore the powerful effects of psychological and social forces, which also shape the brain.

In this way, biological psychiatry, if associated with an almost total dependence on drug treatment, can be as dogmatic as psychoanalysis ever was. Its ideas are based on a core of truth that can be stretched to the

point of faddishness. Drugs are useful tools, but almost never cure mental disorders, most of which remain chronic. Psychiatrists, rushing to gain the respect of medical colleagues, embraced an ideology that is triumphant for now, but covers vast ignorance with a gloss of science. In spite of all the progress of recent decades, neuroscience is still in its infancy. Brain research has not even begun to explain how psychological symptoms develop (Hyman, 2007). It will eventually do better. But it will never be able to reduce all mental phenomena and symptoms to a cellular level, or to neural networks. Unless psychiatry embraces a broader model, it will suffer from a crippled perspective.

Fads in contemporary psychiatry

I wish I could say that psychiatry has outgrown the fads and fallacies of my youth. But it has not. This book will focus on three areas that remain problematic.

The first is its diagnostic system. The *International Classification of Diseases* (ICD) published by the World Health Organization (1993) is official in most countries, with a revision (ICD-11) expected in 2015. This system is standard in European countries. But over the past 30 years, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), developed by the American Psychiatric Association, has become the dominant model in the USA, and has had a strong influence on research and practice all over the world. The latest version (DSM-5), which was published in 2013, does not radically differ from earlier editions. But both ICD and DSM diagnoses have become reified with constant use, even though they are replete with conceptual and practical problems.

Diagnostic manuals are rough-and-ready guides to complex phenomena. Current systems are based almost entirely on observable signs and symptoms, not confirmed by laboratory tests as in the rest of medicine. Some categories are faddish and can expect a short life. At the same time, psychiatric diagnosis has been expanding, sometimes threatening to medicalise the human condition. Mental disorders are being seriously overdiagnosed, leading to inappropriate treatment and unnecessary stigma. We lack a basis for establishing the true boundaries of illness, and as time goes on, diagnosis has crossed into normal variation, leaving hardly anyone free of mental disorder at some point in their life.

A second area of concern is that the current trend in the USA for an almost exclusive reliance on drugs is putatively based on the application of a neuroscience model to practice. The most serious mental disorders (psychoses and melancholic depression) absolutely require medication. However, in the management of common mental disorders (anxiety and depression) drugs are only one of the tools, and many patients do not respond to them. A lot of data on treatment for these conditions support either psychological treatment or a combination of pharmacotherapy and

psychotherapy. Unfortunately, that is not necessarily what happens in practice. Instead, symptoms may be treated 'aggressively' with one or more pharmacological agents, and little time is spent talking about the context of the patient's life.

Thus, practice has swung wildly – from talking without a clear purpose to not talking at all. Contemporary psychiatrists are rarely interested in conducting formal psychotherapy, and even those who have received training in these kinds of interventions may not use them. Talking therapy takes time and commitment. In the USA, the medical insurance system is organised in a way that encourages psychiatrists to offer drug treatment only, accompanied by a brief chat. Even where psychotherapy is covered by insurance in principle, for example in the UK, psychiatrists pass on procedures to psychologists, and these professionals are unfortunately limited in number. Finally, faddishness continues to affect the practice of psychotherapy. Some treatments have been marketed as cure-alls for a very wide variety of problems.

A deeper concern is that those who only prescribe may forget how to listen. As the American psychiatrist Leon Eisenberg once put it, psychiatry has gone from being brainless to being mindless (Eisenberg, 1986). Psychiatric drugs are effective when used for the right indications, but not when applied to problems for which they lack an evidence base. For example, antidepressants can be unimpressive in mild to moderate cases of depression and anxiety, often not much better than placebo. But when patients do not do well with these agents, clinicians are often advised to press on with augmentation and switching. That means prescribing agents originally designed for other problems, which often leads to ineffective polypharmacy associated with highly problematic side-effects. These practices remind me of the way psychoanalysts used to add on more therapy when treatment failed, stubbornly refusing to consider alternatives to their paradigm.

Faddish clinical practices derive from overly simplistic theories. Contemporary views about the aetiology of mental disorders favour the idea that mental symptoms are due to a 'chemical imbalance' or aberrant neural circuits. These theories could turn out to be correct, but are currently not well supported by solid evidence. Even so, many practitioners, and many patients, believe these ideas to be scientific truth. The result is that treatment aims to correct putative imbalances with a 'cocktail' of drugs. Many patients are being given treatments they do not need.

The antidote to fads

The enterprise of science encourages debate and doubt, which are the best correctives for faddish ideas. In the basic sciences, even the most powerful paradigms decline when the weight of evidence fails to support them, but change is slower in medicine. Sick people can be desperate, and

physicians may also seek desperate remedies. I have great sympathy for front-line clinicians who deal with highly distressed patients. But that is why psychiatry, which deals with poorly understood illnesses that cause profound suffering, is so susceptible to faddish ideas. A scientific world view implies a commitment to test all theories before accepting them, and to subject all treatments to clinical trials. Practitioners can emphasise virtues such as patience, humility and caution.

The antidote to fads is thinking scientifically and conducting evidence-based practice. This influential concept, developed by the great Scottish physician Archibald Cochrane, is a principle to which we all pay lip service. But people are prone to preconceptions, and tend to see the world in a way that confirms them. These confirmation biases lie at the heart of fallacious thinking in clinical work. Close attention to the scientific literature helps keep these biases in check, and leads to a more cautious and conservative way of working with patients. Adopting an evidence-based perspective helps us to be comfortable with uncertainty, makes us less likely to harm patients and more likely to help them.

Acknowledgements

Edward Shorter, who read an earlier version of this book, made many useful recommendations for revision. Peter Tyrer was supportive of the project at all stages.

This book is dedicated to family and friends who encouraged me to go into psychiatry.