

REVIVING THE MYTH OF MENTAL ILLNESS

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What do we mean when we say someone has a mental illness? If we are to take the phrase literally, we mean that someone's mind is ill. But can a mind be ill with disease? To believe so, one must make two serious assumptions: one, that the mind is a tangible object with discrete boundaries, and two, that the health of that object can be measured. Both of these assumptions are wrong. Since nothing called a mind exists that can be looked at under a microscope, the former assumption is wrong. The mind is not an object. It follows that the latter assumption is also wrong because only objects with discrete boundaries can be objectively measured. Thus, it is important to note that mental illness in itself – the idea that a mind is ill, is actually a categorical error, like saying the sky is ill or the color green is healthy. There is no such thing as mental illness except by metaphor.

It may seem like trivial semantics, but the mistake that mental illness is something concrete has led to an epidemic of mythology. Every day, someone is told they have a thing inside them called mental illness that must be contended with long-term in order to achieve health. What follows is people learn to see themselves as having ill experiences and well experiences, unlike the normal population who somehow manage to live without sick feelings and thoughts. This attitude can have devastating effects psychologically, as it assures a person that something is wrong with them at their root – their mind, and that they cannot live confidently in their understanding of the world. Physically this attitude can lead to injury, as it assumes and often persuades anyone diagnosed with major mental illness to take risky medications indefinitely as opposed to selectively, which can lead to long-term addiction and a wide range of disabilities, bodily dysfunctions, and disturbing behavior. And socially this attitude can create alienation, ironically reinforced by the attitudes – “You are chronically mentally ill” – of the very people who are supposed to be helpful.

Of course, many psychiatrists, mental health experts, and pharmaceutical companies do not see it this way. Nor do the National Institute of Mental Health and most of the National Alliance on Mental Illness. They claim that each mental illness correlates to a specific neurological disease. Yet you do not need to read studies or have a medical degree to rest assured that mental illness does not correlate to specific neurological diseases. You need only know that there is not a single reliable test for any of the 297 disorders listed in the current diagnostic manual, and not a single reliable test for any of the disorders being proposed for an expanded manual. Not one.

Biopsychiatric researchers proclaim they will soon be able to find these disorders once more nuanced medical technology develops (“We’re in the middle of a revolution,” said Thomas Insel, head of the National Institute of Mental Health, in 2010. “We have the chance to change the world—not tomorrow, but by staying on course.”), but really, how long have we been hearing this? Here’s a Pulitzer Prize winning article from twenty-five years ago:

...psychiatry today stands on the threshold of becoming an exact science, as precise and quantifiable as molecular genetics. Ahead lies an era of psychic engineering, and the development of specialized drugs and therapies to heal sick minds.

We are still waiting. Besides, several aspects of what we do know now about the brain – that it is complex beyond comprehension, that it is capable of producing the same results through multiple pathways, that it is inextricably connected to and influenced by the body, that it is ever-changing in response to the environment – all suggest that finding a neat and discrete pathology in the brain called schizophrenia is simply never going to happen. Attempts to find even general similarities in brain structure and in genes between people diagnosed with mental illness have produced remarkably unconvincing results. You may not know this, because the media often publishes optimistic headlines like Study Hints of Gene Link to Risk of Schizophrenia (New York Times 2008), but fails to cover an analysis that same year called No Significant Association of 14 Candidate Genes With Schizophrenia in a Large European Ancestry (American Journal of Psychiatry 2008), which was published in the world’s most authoritative psychiatric journal and demonstrated that all of the genes presumed to be associated with schizophrenia thus far are not actually associated with schizophrenia at all.

Or, you may not have had forty-five dollars to purchase a recent review called A systematic review of the effects of antipsychotic drugs on brain volume (Psychological Medicine 2010), which concluded that while “there seems to be enough evidence to suggest that antipsychotic drug treatment may play a role in reducing brain volume and increasing CSF or ventricular spaces...”, “Most studies of drug-naive patients examined here did not report or detect differences in total brain volume, global grey-matter volume or CSF volumes between patients and controls...” There are plenty of studies that show differences between the brains of people diagnosed with serious mental illness and the rest of the population, but almost all of those fail to control for the effects of medication on the brain.

When you look at studies of the brains of people diagnosed with serious mental illness who have not taken medication, you find most often that there are no observable differences.

Let us not forget that psychiatry once proclaimed homosexuality a disease. And let us not doubt that if the cultural zeitgeist was still against homosexuality, that biopsychiatry would be hunting for it in the brain and proclaiming it as a legitimate, diagnosable brain disease. What has changed are social values, not scientific evidence.

Even if one day a psychiatrist can show you that a part of your brain is different than everyone else without your particular psychiatric diagnosis, that still does not mean that your brain is diseased. Since the brain is the primary physical house of the mind, it's likely any conscious experience correlates to it. For instance, the experience of love could hypothetically be correlated to biology in your brain just as much as the experience of hearing voices. But what constitutes disease is culturally-defined, so we don't isolate love in the brain and diagnose sufferers of love as having Love Disorder. Now, if you're excessively hyper...

Of course, there is a difference between feeling elevated and thinking the CIA has installed cameras in your mind. The latter can cause much more functional disability within our society. In some contexts, it may be useful to view breakdowns as part of an illness, as long as we recognize that we are talking in metaphor. Some people find great relief in believing they have a brain pathology, and some folks feel invaded and possessed by their experiences to the extent of losing control over their selves. That can certainly feel like a disease taking over. These viewpoints are valid and important if one chooses to make meaning of their experiences in such a way. But let's not pretend this perspective is empirical – “just like having diabetes” – and therefore applicable to all subjects who have similar experiences. Nor should we ever build far-reaching policies and laws upon such a porous foundation. Let us instead call the brain disease hypothesis what it is: a worldview, a theory with contradicting evidence, and a cultural bias. We can then make room for other perspectives, for one person's shrunken amygdala is another's child abuse is another's combat experience is another's religious mission is another's salvation.

What is important is how we build the most connection between people. Talking about experiences in non-clinical, everyday talk provides a bridge between people that is otherwise drowned by psychiatric jargon. I cannot relate to someone who is having a symptom of schizophrenia called paranoia, but I can relate to someone who is really scared. And if I can relate, maybe I can align, be real, and open up with my own learned wisdom instead of parroting prescriptive treatment modalities.

Unfortunately, such alliances are difficult to nurture in a mental health system that assumes clients and staff are fundamentally different. In this system (save progressive organizations and conscientious workers), you're likely to hear professionals at the water cooler talking about how manipulative those Borderlines are, how John just needs to take his meds, and a range of observations in language usually reserved for machines: "John is decompensating. Amy is below her baseline." I know: I've been at that water cooler. And back in my day, I was the subject of such chatter.

Such chatter is not harmless, as I recently relearned when obtaining my own hospital records. The notes declare me "very paranoid" and make observations that "Steven curls up in a ball and cries uncontrollably whenever anyone enters the room" and "Steven is paranoid that others are watching him," which is of course true, and may I suggest a valid response to being in a white concrete wall institution where you are the subject of relentless observation despite unfathomable shame? How is this remedied? A shot of Haldol, multiple Ativan, and Symbyax. No more "smiling inappropriately" after that.

Psychiatrists and prescribing doctors wield enormous authority over their patients. At the very least they should maintain an informed level of skepticism when explaining the nature of behavior to someone who feels out of control. Such caution is an ethical responsibility, but one with rewards, for people in distress will value genuineness more than certainty. Patients should remember that a medical degree does not denote an understanding of consciousness, that people of all stripes have been trying to make sense of the mind forever, and that however unfortunate for industries that stand to make record-breaking profits otherwise, we cannot yet siphon the Great Mystery down into neuronal patterns and genetic variants.