



The bio-bio-bio model of madness

JOHN READ wonders what happened to the 'psycho' and 'social' in explanations of mental illness.

ON 19 August 2005 the American Psychiatric Association published an article, in *Psychiatric News*, entitled 'Big Pharma and American Psychiatry: The Good, the Bad, and the Ugly' (see tinyurl.com/97g7j). It stated:

There is widespread concern at the over-medicalization of mental disorders and the overuse of medications. Financial incentives and managed care have contributed to the notion of a 'quick fix' by taking a pill and reducing the emphasis on psychotherapy and psychosocial treatments. There is much evidence that there is less psychotherapy provided by psychiatrists than 10 years ago. This is true despite the strong evidence base that many psychotherapies are effective used alone or in combination with medications... If we are seen as mere pill pushers and employees of the pharmaceutical industry, our credibility as a profession is compromised. (p.3)

Printing this dissident viewpoint, directly counter to international (particularly US) thinking for the past three decades, was a courageous move by the APA. It reminded me of the late Loren Mosher's magnificent letter of resignation from the APA in 1998:

Psychiatry has been almost completely bought out by the drug companies. The APA could not continue without the pharmaceutical company support of meetings, journal advertising, luncheons, unrestricted educational grants etc. Psychiatrists have become the minions of drug company promotions... No longer do we seek to understand whole persons in their social contexts – rather we are there to realign our patients' neurotransmitters. (www.moshersoteria.com)

What was astonishing about this revival of Mosher's concerns was that it was not just another rebel screaming at the indifference of his profession before resigning – it was Steven Sharfstein, the APA President.

As if in response to Mosher's call to

'Get real about science, politics and money. Label each for what it is,' Sharfstein added: 'Drug company representatives bearing gifts are frequent visitors to psychiatrists' offices and consulting rooms. We should have the wisdom and distance to call these gifts what they are – kickbacks and bribes.'

The first time I attended a psychiatry conference, of the Royal Australian and New Zealand College of Psychiatrists years ago, I was sickened by the extent of the drug industry's presence. Among the endless stalls distributing 'gifts', perfect young bodies in skintight bodysuits

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pranced around enticing psychiatrists to have 'free' massages. My announcing that there were more company representatives listed as delegates than psychiatrists from the whole of New Zealand was met with stony silence.

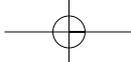
Last year I broke my vow never to attend such conferences again and went to the World Psychiatric Association Congress in Florence. The dominance of the drug companies was reflected in the 'scientific programme', which contained little other than drug studies. After one of my papers ('The treatment of psychosis in the context of childhood trauma') a psychiatrist from Scotland stood up to say: 'Calm down, John. You are winning. We get it. Things are changing.'

But are we winning? What would winning mean? At a conference in Vancouver last year Dr Robin Murray gave an encouraging plenary address. He acknowledged some of the recent research about the role of psychosocial factors influencing schizophrenia. He concluded, however, that 'the schizophrenia wars were over years ago'. He was referring to the truce established under the banner of the 'bio-psycho-social' model, which says that schizophrenia is an interaction between a genetically inherited predisposition and the triggering effect of social stressors.

But I think the war is far from over. I explained that in most wars the invading power is premature in announcing a cessation of hostilities, usually once they have reduced the inhabitants of the invaded country to uncoordinated, sporadic resistance. I said that many of us still feel we are living in occupied territory. The war would end, I continued, only when simplistic biological ideologies and technologies withdrew to the appropriate boundary and acknowledged the damage caused by their illegitimate incursion.

In 2004, along with 23 other contributors from six countries and a range of disciplines (including service users), I published what was consciously intended as a coordinated counter-attack in the 'war'. In the opening chapter of *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*, my co-editors (Richard Bentall and Loren Mosher) and I make our intentions quite clear. We argue that the heightened sensitivity, unusual experiences, distress, despair, confusion and disorganisation that are currently labelled 'schizophrenic' are not symptoms of a medical illness. The notion that 'mental illness is an illness like any other', promulgated by biological psychiatry and the pharmaceutical industry, is not supported by research and is extremely damaging to those with this most stigmatising of psychiatric labels. It is responsible for unwarranted and destructive pessimism about the chances of 'recovery', and has ignored – or even actively discouraged discussion of – what is actually going on in these people's lives, in their families, and in the societies in which they live.

Models of Madness brings together the body of evidence that will increase the confidence of the majority when faced with that misguided but powerful minority who proclaim with all the trappings of scientific and professional expertness: 'It's an illness – so you must take the drugs', by force if necessary. I say 'the majority' because numerous international surveys show that the public (like most mental health professionals and their clients), when asked what causes schizophrenia, cite social factors such as poverty and traumatic



childhoods, far more often than bio-genetic factors (Read & Haslam, 2004).

Psychologists, like other academics and health professionals, tend to be rather thoughtful and kindly folk. Most prefer not to engage in wars, of any kind. So it is understandable that so many psychologists have accepted the so-called bio-psycho-social model. It allows psychologists interested in schizophrenia to study which psychosocial factors trigger the supposed genetic predisposition, as long as they are prepared to ignore the absence of reliability or validity for the construct they are studying (Bentall, 2003). It permits clinical psychologists to help 'schizophrenics' manage their symptoms and prevent relapses by encouraging families to lower their 'expressed emotion' (an odd euphemism for hostility and criticism). Anyway, why bother with the tedious old nature–nurture battle now we know everything is an interaction of the two?

Nevertheless, the supposed integration of perspectives implied by the term 'bio-psycho-social' model since the 1970s is more illusion than reality. An integral part of this has been the 'vulnerability-stress' idea that acknowledges a role for social stressors but only in those who already have a supposed genetic predisposition. Life events have been relegated to the role of 'triggers' of an underlying genetic time-bomb. This is not an integration of models, it is a colonisation of the psychological and social by the biological. The colonisation has involved the ignoring, or vilification, of research showing the role of contextual factors such as neglect, trauma (inside and beyond the family), poverty, racism, sexism, etc. in the etiology of madness. The colonisation even went so far as to invent the euphemism 'psycho-education' for programmes promulgating the illness ideology to individuals and families.

I admit to a barely suppressed 'Yes!' when I read Sharfstein's comment 'We must examine the fact that as a profession, we have allowed the bio-psycho-social model to become the bio-bio-bio model'. So perhaps things really are changing. On a good day I can see plenty of evidence. The international consumer/survivor movement is alive and well (Chamberlin, 2004). British cognitive psychologists are leading a renaissance of the involvement of psychologists in the psychosis field, an area we largely abandoned after the introduction of antipsychotic drugs in the 1950s. They are demonstrating not only that

hallucinations and delusions are perfectly understandable in terms of normal psychological processes (e.g. Garety *et al.*, 2001) but also that cognitive therapy is effective for psychosis (e.g. Kingdon & Turkington, 2005) – with or without medication (Morrison *et al.*, 2004). Several other psychological approaches have also been proven effective (Martindale *et al.*, 2000; Read *et al.*, 2004).

Researchers around the world are less afraid to study psychosocial factors, including the near taboo subject of family dysfunction (Read, Seymour & Mosher, 2004) as causal agents in the etiology of psychosis, rather than as mere triggers or exacerbators of an imaginary or, at best, grossly exaggerated genetic predisposition (Joseph, 2003). Poverty (Read, 2004), urban living (van Os *et al.*, 2001), racism (Karlsen & Nazroo, 2002), other forms of

discrimination (Janssen *et al.*, 2003), child abuse (e.g. Read *et al.*, 2003; Read *et al.*, in press) and having a battered mother (Whitfield *et al.*, 2005) have all been shown to be highly predictive of psychosis. Some even dare to speak of schizophrenia as being preventable via universal programmes enhancing children's safety and quality of life (Davies & Burdett, 2004).

There are other positive signs. I have spoken to full houses at the first two British conferences on trauma and psychosis, our book has received positive reviews in psychiatric journals, and the International Society for the Psychological Treatments of the Schizophrenias and other Psychoses (www.isps.org) has grown enormously.

The true measure of progress, however, is on the front line of practice. The emerging pockets of excellence across the UK must be brought to the attention of managers still harbouring the industry-sponsored notion that drugs are always the first-choice treatment. The simple truths are that human misery is largely inflicted by other people and that the solutions are best based on human – rather than chemical or electrical – interventions. If mental health service users were involved in negotiating the final truce in the 'schizophrenia wars', the bio-bio-bio model would be history. People like choices.

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