INTRODUCTION

> *"In our highly civilized world, we acknowledge that an illness is a serious one by the fact that we don't dare talking directly about it. [...] But when silence or language tricks contribute maintaining an abuse which should be corrected or an affliction which can be relieved, no other solution remains but to speak clearly and to expose the obscenity hiding behind the mantle of words."*
>
> Albert Camus.

Chronic mental disorders are the curse of mankind since the dawn of the human species on earth. They are so to speak a counterpart that some members of the species have to repay in order to allow that all may belong to mankind, they are the ransom the species has to pay for consciousness and language, for these unique features which are distinctive of mankind and which we are so proud of.

Despite the spectacular advances achieved by man in sciences and techniques during the past five or six decades, what we are used to call mental illnesses is still very poorly understood. Remedies intended to relieve them are still far from being satisfactory.

Possibly, we can capture a glimpse of the actual horror these disorders carry only by realizing that they affect and destroy all which, specifically, makes us what we are: our identity, our personality, our feelings, our reason, thus, our humanity. The seemingly persistent ignorance and general lack of concern for chronic mental disorders and their victims at once constitute one of the most blatant and also one of the least tolerable scandals of our supposedly enlightened times.

Being powerless against chronic and severe mental disorders entails that these are ever only euphemistically alluded to, even by those spending their best efforts at relieving them.

A few belgian associations involved in "mental health" have decided to mark year 2001 as "the Year of Mental Health". I am convinced that such decision is just a poor gimmick, a mostly symbolic and somewhat pitiable gesture, a way of paying lip service to "Mental Health", whatever the latter means for them. Its only purpose can be to convey to its actors the cheap, comforting (albeit fallacious) feeling of duty fulfilled.

It is high time to remember what Albert Camus said, about fifty years ago already, and to try to take him at his word, at last. That's what we are beginning to do here.

Prof. Jean Desclin (april 2001)

Short OVERVIEW of THEMES touched on by ARTICLES and FILES available on MENS-SANA.BE

This website was created during year 2001 (which was dubbed "year for mental health worldwide") as an attempt to provide as many french speaking people as possible who are interested in mental illnesses with simple though critically-minded information about what is known (as well as about what is not known!) about some of the most serious chronic psychotic mental disorders, about means made available (or which should be available but are not!) in our country, in order to fight these diseases and to alleviate their numerous ill effects.

Articles and files on this website were written with the purpose of:

- spreading some knowledge and truth about these mental disorders of which, paradoxically, either everybody is convinced that all there is to know about them already is common knowledge, or everybody believes knowing quite enough for his own needs, but actually most refrain from learning anything solid about these disorders because it is suspected that the knowledge might be disturbing or embarassing - and the latter may well be true!

- educating people to better know and to better understand the serious mental disorders. Talking about these is usually shunned, which entails that the actual magnitude of all their ill consequences is not realized by the public at large. This notwithstanding, we might sometimes think that, quite on the contrary, there is too much drivel already about mental illnesses and so-called "mental health", at least if we are to judge by all the false ideas which are being told and further circulated on the subject. Moreover, many officials behave as though they think that mere talk should be enough and could substitute for active advocacy and for actively fighting to change living conditions of the mentally ill;

- helping parents and families who have one of their dear ones afflicted with a severe mental disorder, such as schizophrenia, for example, to acquire a better knowledge and understanding of the illness, because this knowledge and this understanding are essential for being able taking up the everlasting challenge of living with a very dear and near relative who is severely mentally ill.

Most articles and files of MENS SANA always harp on about the physical, i.e. the biological nature of chronic mental disorders, being insistent on the fact that, ***necessarily***, chronic mental disorders have to result from ***material*** alterations of the brain (of its structure, which entails disordered functioning). Other explanations belong to the realm of metaphysics. I am not against metaphysics. I am merely deeply convinced that metaphysics should never mix up with medicine.

Another recurring theme is that of the present state of our scientific knowledge about the brain. Although our knowledge and our means of investigation have made tremendous progress during the past sixty years, we don't know enough yet to enable psychiatry and psychiatrists to treat satisfactorily all instances of severe mental disorders, let alone to enable curing every case of schizophrenia, for example.

Therefore, it must be repeated again and again that quite a number of social measures also should be taken in order to compensate for the numerous deficiencies (impaired awareness of the disorder, loss of autonomy, etc.) which are the consequences of the disease, consequences which available treatments quite frequently cannot yet overcome completely.

Some people in this country then advocate "psychotherapies", whereas others, mainly our officials and our belgian "professionals" in charge of public health talk about "prevention of mental disorders" and "promoting mental health". This is just another easy way of letting out a lot of hot air to impress gullible persons. By doing so, they don't help the mentally ill of this country in any way but they rather delay finding and applying practical means for improving the living conditions and fate of these ill persons.

Exposing the ins and outs of the situation of our mentally ill in Belgium, in order to actually improve their treatments and to eventually change their fate, that's all what this website is about.

This belgian website endeavours telling to everybody who is interested ("everybody whom it may concern") what should be known today

about some of the most severe chronic mental illnesses such as, for example, what psychiatrists call "schizophrenia". Bipolar disorder and unipolar depression (mood disorders) also will be evoked, although more incidentally. The articles to be found on this website were intended chiefly for belgian french speaking readers. Some of them were translated in english, however, in order to allow possibly interested persons from other countries to know what this website is about, and to show to all that the situation of mentally ill persons in Belgium is far from being as rosy as officials of this country usually claim it to be. We offer these readers our apologies for the poor quality of the english translations.

We will not claim proposing an apparently highbrow and pretentious definition of mental illnesses by using involved but empty language. Everybody can understand (that's our purpose!) even if only the obvious is merely pointed out: chronic mental illnesses to be evoked here are the result of faulty precocious development of this enormous and exceedingly intricate biological machine that is our brain.

Everybody can understand when it is said that such faulty development should entail faulty functioning of the brain, affecting mainly our higher mental functions (those which developed last during species evolution). These are the functions which make everyone of us what he /she is, they enable us to live, to perceive, to feel, to think, to act and to react (to behave) in a consistent way. In short, they are the features which are evidence, for all of us, of our belonging to mankind.

Psychological or psychiatric pseudotechnical jargon will be avoided, since it is quite unnecessary and usually useful only for muddling issues, not for enlightening them (at least when used by most of our french speaking psychiatrists!)
We will try providing explanations available from today's neuroscience findings, which should enable us to have a better understanding of how different our brain is from all our other organs (*this is of paramount importance because brain structure and functioning are systematically overlooked, especially by our psychiatrists*). In doing so, we will be led to debunk a number of generally accepted ideas still current in the public at large about chronic mental illnesses (ideas which some of our so-called "professionals" seem very keen indeed on keeping alive). We thus intend to demystify these ideas.

- **To demystify** should not be mistaken for making the mental illnesses less fearsome or less frightening.
- **To demystify** does not imply that all explanations are already available, that neuroscience already should be able to provide answers to all our questions.
- **To demystify** has nothing in common with dreaming up imaginary explanations in order to put one's mind at ease when facing the unknown, as a frightened child might do when surrounded by the night's darkness. Neither is it thinking up fancy, childish and simplistic explanations or, on the contrary, convoluted constructs conveniently suited to circumstances of the moment, such as those one would think up to answer the unexpected, embarrassing questions from a curious child. Nor is it contriving spurious explanations intended to hide the fact that the true answers are not known.
- **To demystify** means to say and to explain what we reasonably think is known, but it also means that we say what is not known as well (we should recognize where our knowledge stops). It is to tell what scientists think is plausible and why they think it is so; it is also to tell what scientists have good reasons to dismiss or what they have good reasons to believe should be unlikely.
- **To demystify** is to honestly take on one's functions, one's knowledge, but it also means that one should be able, in a responsible way, to acknowledge the gaps in one's own knowledge. It is to act and to treat other persons as adult and responsible humans. To

demystify is to show to everybody the respect he/she deserves, by providing him/her with the means (the knowledge) to judge and to decide by him-/ herself, to freely make choices with full knowledge of facts. It is to inform other persons correctly, in order that the adults that they are will not think they are ignorant children, as some would perhaps have them believing.

On this website, *there will be no talk about those disorders that humans inflict on themselves*: addictions to various socially admitted drugs such as alcohol and tobacco, nor about such disorders as arising from the use of much more immediately toxic drugs such as cocaine, heroin, crack, etc., which very rapidly become impossible to dispense with because they alter metabolism for a very long time or even permanently.

On this website, *properties deemed specific* of every individual psychoactive medication (neuroleptics, antipsychotics, antidepressors) available in Belgium will not be reviewed. Indeed, it is felt that predicted effects on symptoms, as described in the explanatory leaflets provided by the pharmaceutical firms, *are just an illusion which is misleading all: lay persons, general practitioners and psychiatrists alike*. Every mentally ill person is unique and constitutes a special case. To put it in another way, one could say that there is no well-defined mental disorder that would, always and with any certainty, predictably benefit from a given specific medication (such as insulin for diabetes, for example): there are only individual cases. Effects (beneficial or not) of a given medication on this ill person or on another one are never predictable with any degree of certainty. There is no medication which would be definitely good against this given "illness" whereas it would be definitely bad against that other one. Some medication will prove good - or bad - for Mr or Mrs so-and-so, ***only*** because they found out by trying it out.
The most recently available medication will of course be highly vaunted by the pharmaceutics company that developed it and markets it. This in no way ensures that it will be more effective on the illness of Mr or Mrs so-and-so than another, possibly older product. That's why we won't try flooding readers with a stream of names of medications, with the lengthy descriptions of the biochemical as well as "psychotropic" properties of their molecules. This would not help them in any way. Let us leave that to those who have the experience of such matters (or who are supposed to): neurologists, "biological" psychiatrists and pharmacologists.
We will also leave that to those who mistake browsing through lists of medications for understanding of their contents, those who cannot distinguish between quoting ill-digested readings and actual knowledge, but who seem to believe that the former should be enough to enhance their credibility and their image in the public's eye.

Unlike what you often may find on numerous other websites, we will not hint at fancy promises of the impending discovery of neuroleptics which would be better than those available today because they should be devoid of bad side effects. No presently available neuroleptic medication is specific enough (*of what, by the way?*) to be devoid of side effects and, automatically as well as by nature, any side effects cannot be anything but a nuisance.

Today, nobody has the slightest idea about what specific brain structure a psychotropic medication should target in order to suppress or to merely but significanty alleviate psychotic troubles. Therefore, claims of better specificity of this or that medication are just either wishful thinking or scams, you are to choose the most likely of these two possibilities.

On this website, we will more especially endeavour to make clear what the features of chronic mental illnesses necessarily entail for treatments and care available nowadays. Such consequences of characteristics specific of chronic mental disorders are very different from those resulting from other, so-called physical diseases. That is rarely quite clear to public health policy makers.

Although causes and mechanisms of chronic mental disorders are still unknown, they have to be very concrete (material), notwithstanding all claims to the contrary. Hence, although available treatments provide no cure, although they can only alleviate some of the signs and symptoms of the disorders, they should be very concrete as well (*i.e. medication*). With very few, quite

unpredictable exceptions, and even when these medications are effective, their results will not be entirely satisfactory and they will have some drawbacks.
In quite a number of cases of medicated patients, the patients will need some additional care as a consequence of the only partial or inadequate results of the medication. This should not consist of some arbitrary or fancy so-called "psychotherapy" as described in manuals, it should consist of caregivers providing guidance and support custom-tailored to the needs of every individual case (giving to such care the name of *psychotherapy* doesn't make it more effective though some "therapists" may find it gratifying to themselves or impressive to gullible persons).

Still other consequences very logically result from all that has been said above. When you think about it, these consequences should be obvious, but those in charge of "mental health" do not seem to be yet aware of them, however. Possibly, that's why there is not much talk about it, even on the web!
Among other examples, deciding what their problems are by merely observing the ill persons (observation is almost the only tool available), i.e. detecting what is O.K. and what is amiss with them requires that "professionals" (psychiatrists, psychologists, caregivers etc.) continuously spend quite a lot of time with their patients, perhaps during days and weeks or even months on end.
Such enduring and sustained close observation is also required in order to assess the effects of medication, to recognize what it improves, what it possibly worsens, what it fails to change.
Watchful and continuous observation of the patients (living at their sides) is also the only means allowing to decide whether learning of social behaviours ("skills") is still possible or if motivation and abilities are too altered to use them for practical purposes.

To force a mentally ill person who has lost the required abilities, to behave in society in the same way as a well and healthy person would do, is akin to forcing a paraplegic person (unrecognized as such) to run across the highway during high traffic (thus, we will see if he/she can do it without getting crushed).
That's no therapy, that's not care, that's inflicting on the person a sadistic and criminal torture under the pretense of socially rehabilitating him/her.

True care consists, first in administering to every patient the medication which proves to be best suited to his/her individual needs, second in providing ill persons with places, living quarters and living conditions taking their handicaps into account. Forcing mentally ill people to adapt to society though we are not able to provide them with the means to do so (*even worse, our will to help effectively might be lacking!*), you may not call that treatment nor looking after them. There is only one fitting word for that: to torture.

Providing adequate care thus implies spending much time, having numerous motivated and qualified personnel available, all involving heavy public expenditures. Political leaders do not seem eager to tackle the problem.
In this country, everything that concerns "mental health" is swollen with quite a lot of hot air. The purpose of this website is to help people to see through all the usual baloney.

BELGIAN FICTIONS

In Belgium, our society boasts of a system of social welfare and health care about which it is frequently said that they could be held up as an example for other countries to follow. Yet, what does this system actually do for people who are victims of chronic mental illnesses?

(Alternative titles might be: A deceptively low-cost system of fictions which ensure clear conscience quite conveniently, or Mental Health: a land of Make-Believe.)

Numerous clichés and beliefs yet more numerous are going around in the public about mental illnesses, so-called "Mental Health", about psychiatry and psychiatrists, about living conditions of chronically mentally ill persons. Generally, questioning these beliefs is carefully avoided. Many feel that doubting their validity might jeopardize the credibility and the respectability of established institutions, professions, habits and traditions which have been taken for granted for so long that there would be no point in wondering now about their actual meanings and purposes. Nor would it seem to be worth the trouble to allow oneself to become concerned about them.

These ideas and beliefs blend so well with our mental and social landscape that they have become integral parts of it, we don't think consciously about them any more. Besides, in the public at large, who would take the trouble bothering in earnest about problems probably so scarce that even the mere need to mention them almost never arises?

These beliefs notwithstanding, psychoses are chronic mental illnesses which affect many more persons than is usually and openly acknowledged. Indeed, their overall prevalence in the population (in all countries) is estimated to be about not less than 3 percent. Which means that, even if we ourselves and our near relatives are, until now, lucky enough to have been spared this kind of illness, we nonetheless all know, among our friends, acquaintances or those with whom we come in contact every day, the one or other family having one of its members afflicted with a serious chronic mental illness. Such also could happen in our own family, to ourselves or to someone very near and very dear to us.

Thus, willy-nilly, we are all involved in the problem of mental ilnesses, we should feel concerned by it.

In the following, we shall try to uncover some of the more common fictions current about mental illnesses. In literature excepted, fictions serve no purpose. In real life, they prove pernicious because they prevent progress and stand in the way of improvement in the present situation of the ill persons. They should be exposed, they should be debunked. The reasons why such fictions are so long-lived and so hard to dispose of are left for all to find out by themselves. One should be aware that:

Fictions are convenient illusions, the easiest and cheapest immediately at hand subtitutes for the effective means not available or deemed not affordable by deciders who usually find it easier to forget or to overlook what they actually were put in charge of when they were appointed.

Our modern and industrialized society periodically undergoes economic crises with their share of social problems. The latter entail marginalization and exclusion of individuals and whole families. Unemployment, impoverishment, illiteracy cause social exclusion. In turn, these are the sources of dire straits and of more or less obvious psychological distress.

Such psychological distress which, according to some, would reflect the "discomfort" and result from the "bad way of living" in our society, it is for sure very real. Quite obviously, its true and

well-known causes are of an economic and social nature. Nobody is unaware of its equally obvious cure: employment decently payed, which in turn ensures solvency, provides access to food, allows for decent living quarters, instruction, health care, thus, in brief, which ensures a decent level of "quality of life", a minimum of human dignity and self-respect.

For want of effective remedies for the present socio-economic problems, causes and consequences become mixed up, unwittingly or possibly less so. Psychological consequences of poor living conditions are now called mental or psychic disorders which are held responsible for precariousness as well as for exclusion (though the latter are in fact the actual sources of this type of psychological distress). Thus, socio-economic problems are turned into so-called "mental health" problems. From now on, all problems are supposed to be solved by "taking measures" (*mostly administrative in nature*) or "setting up committees" (*devoted mostly to talks about drafts of regulations*) whose mere names should seem to warrant the universal cure. The public administration, the specific institution called "Mental Health" steps in. It is supposed to be in charge of all problems, which it does in a typically administrative, anonymous and frequently kafkaesque way, never very user-friendly even to any reasonably healthy human being and, particularly, a way usually of no usefulness whatsoever for those very persons who are indeed afflicted with a true chronic psychotic disorder, a way of dispensing care very poorly suited indeed to the real needs of persons with a serious psychiatric disorder.

The bureaucratic panacea now known by the name of "Mental Health" is filled with clerks, psychiatrists, psychologists, social workers, educators, psychologists' assistants, nurses, etc., etc. These technicians and specialists of the psycho-social sphere are, self-evidently, blessed with all required qualities: they are supposed to be conscientious, all-knowing, dedicated, expert and competent, easily approachable by and continuously available to both the public and their charges. They are supposed to help their charges along in the unending maze of public or private social organisms, from one office to the next one, from one counter to the next one. Some officials of this new sort spend most of their time filling in numerous forms testifying to their humanitarian and socially beneficial activity. Since they actually have nothing concrete to offer to their customers, no decently payed employment available to unearth for them, they content themselves with turning the economically and socially underprivileged into individuals permanently in need of social assistance and into "socially ill" persons. From now on they label them "psychically ill" persons who should be treated by doctors and given psychotherapy, who should benefit from efforts at "inclusion" into society or should be "rehabilitated". Merely by doing so, they convince themselves of their humanitarian role, of their own psychological and psychiatric know-how. By doing so, they also feel they prove to all - but especially and most importantly to themselves - their value to the community, their importance amidst the social system. They think that, somehow, they legitimate their own positions and their salaries, that they deserve well of society.

The same persons advise the creations of so-called "centres" and other places and facilities with grand-sounding names and impressive acronyms. They thus provide other psychologists, social workers, psychiatrists, etc. with opportunities of jobs or positions wherein they may set up and find their reason for being: mainly to spout as convincingly as they think possible about persons allegedly mentally ill. They claim to think out the ways for treating and curing them, they usually recommend "treatments" without caring much about whether these treatments are to the point, nor do they care to know whether the practical means to implement these "therapies" actually do exist, whether the ill persons can have access to them. They try to keep their charges busy with miscellaneous tasks described as educational or rehabilitating, although they are usually quite devoid of any interest or of whatever practical value. But why, indeed, should one risk expressing efficiency in terms of results arrived at, when it is more expedient to resort to seductively printed pamphlets deliberately substituting advertisements of good intentions for means and achievements actually lacking?

Rest assured that the following fiction is only a fantasy, a working hypothesis. For example, what would be thought of an airline company whose directors, for financial reasons, rather than maintaining their planes in good repair, would prefer hiring "psychological support teams" to cater

for the psychological needs of relatives of casualties in crashed airplanes? Such preposterous and outrageous situation is, of course, a pure fantasy, a rather poor science fiction story, all the more so since the make-believe airline companies responsible for such policies certainly would have a hard time convincing their customers that teams of psychologists and psychiatrists should be able to prevent planes from crashing down or, failing that, should be able to make people forget or put up with these disasters.

In real life, however, it doesn't seem too difficult for the "Mental Health" public administration and private organizations to convince the public, for their own causes' sake, that the socially underprivileged people owe their plight only to "psychic" factors and that seeing to the latter should be remedy enough for all consequences of economic and social bad living circumstances. Such biased interpretation carries some benefits. For example, it allows to temporarily cross out unemployed people from the list of job-seekers; meanwhile, it diverts their attention from their true problems (unemployment) by setting them other tasks and, at the same time, it allows the organizations "promoting mental health" to enhance their humanitarian image both in the public's eye and in their own. As a tribute to their efforts, the cost of such devices may even be made out to look quite considerable (thus commendable), albeit conveniently less so than the burden that the right, long-term but discarded economic and social solutions would have entailed (which may also be construed as a credit to their sense of thrift).

In summary: let us refrain from trying solving the actual problems, just let us try to make people forget them. Let us replace the actual problems with other contrived and fictitious ones which may be made out to look as if they are under control only at the cost of commendable efforts. Let us then pretend that everything has been taken care of, that everything is resolved.

One example of this blatant brainwashing (or psychological disinformation) should suffice to illustrate was has been said above. Our experts and representatives in charge of "Mental Health" proclaim that they most definitely put the emphasis on prevention. They seem to experience no difficulty in persuading political authorities of the validity of such claim. Common knowledge however tells us, and scientific experts from all countries agree on the fact that
causes and mechanisms of chronic mental illnesses (psychoses) are still unknown and there are today no known means available to predict the outbreak of a chronic psychosis bound to develop in someone.

Are we thus all thought of as gullible simpletons (suckers) who may be readily enticed into believing that unpredictable events by unknown causes and mechanisms ever could be prevented from happening?

In the meanwhile, what are the officials in charge of this presently obviously impossible prevention spending their precious and expensive time at? (please don't mention the taxpayers' money...) Indulging in omphaloskepsis? Tending to their chirotrichosis (in french speaking countries) or (for those who speak english) possibly nursing that extra bone they sometimes might be suspected of harbouring in their leg?

How long will people bear being fed such nonsense by politicians unaware of the features of mental illnesses who, when they take decisions, are relying mostly on the advice of so-called professional experts actually more intent on obliging them than on providing them with objective and accurate information?

Since "Mental Health" exists, its promoters quite naturally want to make the utmost of it. Hence, it is assumed it should deal with all persons whom, from now on, they call mentally (psychically) ill persons (both the true and the alleged ones). Why not also substitute this "Mental Health" for the "Psychiatric Institutions", the "Psychiatric Hospitals" and the "Psychiatric Departments of General Hospitals"? Why not entrust it with open "ambulatory" psychiatry whose humanitarian and social qualities, whose claims to therapeutic efficacy and to "social inclusion", whose allegedly cheaper and more rational management are highly vaunted and contrasted with the very poor features of psychiatry centered on hospitals, i.e. asylums, high costs, iatrogenicity and, to say it all in only

four words, the appallingly bad reputation?
Accordingly, at one single touch of its magic wand, "Mental Health" administration has accomplished at least two, perhaps even three quite remarkable feats at once:

1) it has turned many people from unemployed individuals into socially and psychically ill persons who require social, psychological and psychiatric assistance (*they have to wait*) in order to find and get a job;

2) because it does not distinguish socially underprivileged persons adrift in society from truly and seriously mentally ill persons (for example, chronic psychotic individuals), the latter cease to exist in their own right since they are implicitly supposed to have been taken care of with the first; as a consequence of this convenient vanishing act, the numbers of beds in psychiatric hospitals reserved for mentally ill persons could be ruthlessly reduced, which could be both taken as evidence of better management but also construed as indirect evidence of better therapeutic policies resulting in more numerous (*but spurious*) cures;

3) as a consequence of the two previous points, "Mental Health" administration may lull the public at large into believing that everything around them and in the brave new world of "good mental health" is taken care of and under control. **Dreadful mental illnesses are never mentioned although there is quite a lot of drivel about "mental health", which of course sounds more comforting in the ears of the uninformed majority**. Refraining from mentioning mental illnesses may lend credence to the belief that so-called "mental health" is a general concept understood by everyone, that it is well defined and self-explanatory, some sort of synonym for universal well-being that is not in any way related to threatening mental illnesses. Mental illnesses may sometimes be fleetingly evoked as unlikely events happening in another world far away from us, but it is implicitly assumed that they certainly should be kept at bay in ours, thanks due to the watchful attention of caring "Mental **Health**".

Officicials of "Mental Health" administration try to substantiate the **fiction according to which "psychic disorders" result from inadequate ways of life, which themselves would reflect some of the bad ways of modern society: mental illnesses would be mere maladjustments to bad society.** According to these experts, this kind of alleged maladjustment should be taken care of by "psycho-social" measures. Such standpoint is completely mistaken. **Mental illnesses are not a curse of modern society. Everyone should know that they are with man since the dawn of the human species, that they are part of the genetic inheritance of mankind as a whole**.

For many **technical** reasons which should be obvious, current "open" and "ambulatory" "Mental Health" facilities in this country are unable to diagnose chronic psychotic disorders: indeed, such disorders can almost never be identified at once ("on the fly") by a psychiatrist consulted and talked to during too few minutes in his office. Moreover, most truly mentally ill persons are usually not consulting at the ambulatory mental health facilities (since it is their illness which makes them unaware that something is amiss with them). As a consequence of this, they generally bypass "ambulatory mental health centers". They usually end up as emergency cases for the psychiatric ward and are thus directly rushed to the hospital. Hence, needs for beds set aside for psychiatric cases being calculated from the numbers of patients going through these "ambulatory structures" and sent from there to the hospital, it is no wonder that they should be grossly underestimated and that the administration might feel entitled to brag about reducing expensive and so-called superfluous "psychiatric means" (numbers of beds and of personnel) in psychiatric hospitals.

Mental illnesses are thought of as being quite different from illnesses of the body: they are depicted as illnesses "of the mind", which are said to be non material psychic dysfunctions (or so-called "functional troubles" devoid of organic basis). That's not only one more fiction, it is sheer nonsense.

This fiction keeps in line with the previous one. It denies the existence of genuinely mentally ill persons, i.e. persons chronically afflicted with psychoses. It shoves them into the big rag-bag

holding all victims allegedly made ill by the "alienating society". They thus become additional victims of this modern world which is blamed for making people mad, they should all benefit from the same "psycho-social" measures which should relieve their "functional psychic ailments".

Moreover, what is the meaning of "functional disorders" without material ("organic") basis? Even a very astute philosopher would be reluctant to explain such concept! I wonder what most sensible people would think of their watchmaker, their garage mechanic, their radio repairman, their computer dealer, etc., if any of these professionals were to tell them - about their broken down watch (or car, radio, T.V., computer, etc.) - : "I don't find any defect, outwardly it looks O.K. to me, it should tick (or run, or work, or whatever); but since it doesn't, let us say that the trouble is purely "functional". One may bet they would try looking for another professional for better service, and everybody would agree with such decision. However, most mental health professionals in this country still believe that functional mental disorders can exist independently of any biological, organic, material basis. Then, the true name for such phenomenon actually should be ***pure magic***, but certainly not scientific knowledge as they would us believing! Such behavior is proof that many of these "professionals" still hold that the mind can exist independently of (outside?) the brain. Neuroscientists know better, but they can't yet much help us. This explains why quacks, faith healers, psychics, or other proponents of exotic "psychotherapies" resting on pure fancies still have so much success.

Public opinion about psychiatry and mental disorders is still ridden by a host of fictions in dire need of debunking by a minimum amount of explanations about features and nature of chronic psychoses. Indeed, numerous people still believe - or perhaps would sometimes have us to believe - that psychoses, though they are felt as threatening, are but imaginary or virtual troubles, as sometimes suggested by sentences such as "arousing psychosis", for example. A majority among us think of mental disorders being so different from other illnesses that they take on a disquieting aura of mystery and threat. That's a basic error, but it is so common that it is taken as a truism. The ignorance of lay persons about these disorders is the source of countless misunderstandings which some apparently would like to maintain.

Erroneous ideas about chronic mental disorders should be fought against by competent professionals who also should explain to families of ill persons (and, when possible, to the ill persons themselves) what is known - as well as what is not! - of the nature of chronic mental disorders. In this country, however, such information policy is anything but customary. Families of mentally ill persons have to learn by themselves, the hard way.

Most chronic mental illnesses have in common that they express themselves by signs and symptoms which are not material, not concrete, which are rather difficult to measure: they are ways of speech, beliefs, attitudes, behaviors, feelings, moods possibly sharply contrasting with those usually encountered in the general population who may thus think of them as incomprehensible or embarrassing or even offending.

First, this absence of material signs, the lack of concrete evidence, which is so different from what happens with most so-called "somatic" illnesses, seems to vindicate the saying which goes: "don't pay attention, it's nothing, it's fantasy, it happens in his/her head", as if the human skull were a mere empty shell!

Second, signs and symptoms of mental illnesses are **alterations of traits and of "psychological functions"**. From force of habit or because that way is easier, we look at those traits and functions as if they were concrete entities, almost as pre-existing material objects: memory, thought, reasoning, anger, joy, will, etc., etc. We forget that these are products of our brain, more or less instantaneous constructions continuously started afresh, always short-lived. We perceive only the end products but nothing of the processes required for their production which requires countless neurons in our brain. These are the unseen processes which go awry in mental illnesses, resulting in altered "traits" and "functions".

Third, our personality, our mental functions, our perceptions, our capacity to communicate with

the surrounding world as well as with the world inside ourself, all depend on the integrity and on the right organization of the biological constituents of our brain, which may be summarized as:

"We are our brain in our body".

The brain is the most extraordinary and most complex of all our organs and, contrasting with all others, it is almost entirely devoted to processing information. Most cells constituting it, the neurons, are unique and irreplaceable individuals. Continuously receiving signals from and sending signals to all parts of our body, the brain is responsible for the coordination of all our organs and commands them all, it ensures the unity and the identity of the whole: **the brain is the director of the orchestra that we are**.

When the structural integrity of the brain is precociously and deeply altered, relationships between its different parts become disorganized; the psychose eventually may develop, the only known ways of communicating both with oneself and with the surrounding world then vanish. That's the true alienation: the **orchestra director is no more available**, cacophony breaks out!

Mental disorders are illnesses which, in essence, are not different from other illnesses. It's the organ which they involve, i.e. the brain, which makes all the difference, because of its unique complexity and its central role in all our functions and in our identity.

In this country, psychiatrists are used to divide mental disorders into two different categories: neuroses and psychoses (a distinction which has been discarded by the latest APA's DSMIV).

Neuroses affect mood and emotions, they express themselves as phobias, erroneous assesments and interpretations of events, of values, of other persons and of oneself. Although neurotic troubles may be exceedingly obsessive and may prove to be quite a nuisance in everyday life, they usually are not severe enough to prevent their victims from reasoning and from becoming aware that they experience psychologic problems. Frequently, neurotic persons will be able to decide, on their own, to consult a doctor, a psychologist, a psychanalyst or a psychiatrist. These professionals may help them: by listening to them, they may be able to guide their introspection, sometimes with the help of some medication in cases of emergency (anxiolytics, antidepressors, tranquillizers, etc.)

Neuroscientists have evidence that neuroses are disorders acquired through experience, after rather than during the development of the brain. They arise after the normal development of the brain has been completed (which has occurred in the embryo, in infancy and during childhood). All major cerebral circuits being normally developed, the brain machinery is only superficially affected in neuroses, it remains able to correct these "superficial errors" by learning anew with the help of outside professional help: neurotic persons may thus be able to become aware, by themselves, of the erroneous character of their beliefs. This realization constitutes the most important first step towards rehabilitation and cure of a neurose. This is possible because the cerebral structures needed to support them are present. They had completed their normal overall organization before the neurose developed. Neuronal connections are present which enable neurons to develop new synapses under new, correct stimuli.

Psychotic disorders such as **schizophrenic disorders and bipolar disorders** (the only ones mentioned here because they are the most frequent and the most devastating ones) are quite another matter. These are mental disorders which so severely alter mental functions in such a way that their victims often are not able to become aware that the origin of the problems they experience lies with themselves. It does not occur to them that they should go to the doctor, they don't feel the need for it. When consultation of a doctor is suggested (by a relative or a friend), they may reject the idea obdurately. This does not reflect a stubborn "psychological" denying of the illness. It corresponds to what neurologists call **anosognosia**. Anosognosia is the inability of someone to become aware of his/her own troubles and defects and of the abnormal character of his/her symptoms, although they are obvious to all except to their own victim. This lack of awareness results from the deficiency of the cerebral circuits (in the frontal cerebral cortex) whose

integrity is a prerequisite basis for the critical mind (belgian psychologists and psychiatrists seem to ignore anosognosia, they never mention it).

Causes and mechanisms of psychoses are still unknown, and those who claim otherwise either don't know what they are talking about, or they misrepresent truth.

Even the existence of psychoses as actually well distinct entities (schizophrenia, maniaco-depressive or bipolar disorder, for instance) is at issue between psychiatrists. In no way should these disputes be taken as evidence that the numerous and very diverse mental disorders which are bundled up under these names should not exist. Indeed, they exist, their victims are testimony for it! These issues only mean that we have no certainty about the validity of classifications and of groupings and orderings that psychiatrists, all over the world and since many years, are making up of these troubles on very shaky grounds. Medical doctors would say that **psychoses are syndromes, they are neither specific nor well-defined diseases**. They are disorders so to speak made up of bits and pieces, some kind of puzzles, the pictures which eventually come to emerge from putting their pieces together are always unsure and questionable. This sometimes entices some psychiatrists in our country, possibly because they prefer sophisms and provocation to medicine, to claim that schizophrenia does not exist, which they then believe would entitle them to refrain from treating people ill with this non existent disease.
Schizophrenia as a well defined disease entity might in fact have no actual existence. But ill persons afflicted with schizophrenia nevertheless do indeed exist; who would say one need not be concerned by their fate?

Although specific causes of these severe chronic disorders are still unknown, there is evidence that causal factors are in part genetic (they belong to the genetic inheritance of the human species as a whole), environmental factors also come into play. Contrasting with what happens for neuroses, factors responsible for the development of psychoses are likely to intervene much earlier during brain development (it could be anytime from as early as the 4th week *in utero* and, according to some, up to the end of the teenage years). It should be no great wonder then if faults in brain structure should be much deeper and extensive than in neuroses, nor is it likey that they would be amenable to the same methods of treatment.

The methods of treatment consist of the entire collection of remedies and treatments which should be able, if not to cure the illness, at least to relieve its symptoms and consequences. Everybody is convinced to know at least a few things about the general meanings of medical care and treatments that have to do with non psychiatric medicine. Since our psychiatrists also are "doctors", **the fiction arises according to which, by analogy with the other branches of medicine, psychiatric care and treatments also should be but specialized medical treatments**. At least, that's what the lay persons and the public at large usually believe, because psychiatric treatments and care are also given in hospitals where doctors work. Moreover, since advances in all medical treatments have been so great lately, surely psychiatric treatments should be no exception? That's an illusion. At least in this country, psychiatric care and treatments have nothing in common with medical treatment in the usual medical sense of these two words.

This situation very logically results from the stagnation of our scientific knowledge in the field of psychiatry as compared with other fields of biology, of medicine and of the neurosciences more specifically. This poor state of affairs can only be deplored, psychiatrists should not be blamed for it. Nor should it be ignored, however, because this would be both pointless and dangerous!

Especially in our west european french speaking countries, psychiatry still experiences some difficulty giving up the cartesian view of duality of mind and body. This conception frequently leads psychiatry to view itself and to behave more like a theoretical and disembodied philosophy (sometimes even like a theology) rather than as a natural science devoted to the study of physical reality which we are part of: some psychiatrists still call it "the medicine of the mind". You may think that such formula sounds fine only as long as you don't wonder what it actually does mean.

Recent advances in neuroscience (since some sixty years) now allow to turn research about psychoses and their treatments into directions quite distinct from those of previous pseudoscientific theories which were all the craze for more than half of the 20th century, those very theories which generated more misery than they ever were able to alleviate.

Currently best supported scientific theories hold that chronic psychoses are the outward signs resulting from dysfunction of a yet unknown number of brain structures which are unable to work together harmoniously. Such dysfunction would be the consequence of developmental anomalies which could occur already very early during embryogenesis. Because the visible onset of the schizophrenic illness usually occurs some time after puberty in males and still later in females, some (mainly U.S.) psychiatrists believe that brain developmental anomalies responsible for schizophrenic disorders could also occur much later (up to 25-30 years), but this is yet another debatable question. Nevertheless, these developmental "accidents" certainly result from the interplay of genetic and environmental factors, the latter being unknown to the present day.

Even if advances in neurosciences since 50-60 years are tremendous and although scientists may rightly feel very pleased about this progress, gaps in our knowledge are still much larger and more numerous than some would acknowledge. Our central nervous system is the most complex biological machine scientists ever tried to tackle (about 10 billion neurons!) Today's modern tools - powerful ultramicroscopes, biochemistry, isotopes, computers, computer-assisted medical imagery, etc., - which allow to painstakingly, systematically and methodically explore the functioning of the human brain, were developed only lately, the oldest among them being not quite sixty years old yet. These tools enable us to garner the basic biological data about all the organs (and their functions) of our body, ***including the brain and its mental activities***. Even still quite recently, many would believe that such knowledge would be forever out of reach. They thought this would justify their dreaming up fancy "explanatory" theories, which should be more easily and sooner arrived at than what the more demanding scientific approach ever could accomplish. Woolly theories were often said to be revolutionary or to constitute discoveries of genius, but none of them actually ever could be verified nor falsified, which means that they had no scientific basis whatsoever.

Such crackpot theories could only mislead psychiatry into dead ends, sterilize it and bring it into disrepute. Nevertheless, many lay persons and even numerous psychiatrists fell for these theories, because they had a "new" and provocative feel to them, and "thinkers" in intellectual circles could look "progressive" by spouting them. Many of the wrong clues thus followed up by psychiatry were all the raving craze for quite a long time, which explains that numerous people still believe in them, even today. Fortunately, "psychological" explanatory theories of psychoses have nowadays gone out of favor with the majority of competent professionals.

It has been acknowledged at last that, in families, the "bad upbringing" (i.e. the supposedly unconventional way of raising children by parents) never caused nor triggered off the psychose in a child whereas the other siblings would be spared. Conversely, it is also recognized that "good upbringing" (the "socially or politically correct way") never could protect from psychose those among siblings who were prone to develop it.
Quite remarkably, professionals of "mental health" as well as lay persons do not yet seem ready to acknowledge all implications of these observations (with regard to prevention, for example) without - to say the least - reservations. Although they are nowadays moribund, intuitive "psychological" and simplistic explanations of psychotic disorders and of their causes always crop up again when it comes to treatments.

According to the limited scientific knowledge presently available on the one hand and, on the other hand, in keeping with the untestable constructs which belgian psychiatry doesn't yet succeed in getting rid of completely, treatments of psychotic disorders are divided into two sets: medicines and psychotherapies.

Medicines

Abnormal brain levels of synaptic transmitters - such as dopamine and serotonine - have been observed in many cases of psychotic disorders such as schizophrenia, deep depression and bipolar disorder. These observations warranted administering drugs modifying either the neuronal release of these transmitters or their effects on target neurons. Imbalance between transmitters was suspected to be responsible for at least part of the mental "symptoms". There was some hope that interfering with these transmitters might correct the imbalance, which thus might be beneficial. This brought about the very rapid development of a tremendous number of psychotropic drugs, **neuroleptics** and **antidepressors**, among others.

The use of these medicines is purely empiric. Their (ill or beneficial) effects on this or another ill person can never be predicted, they have to try them out. Since these drugs actually do not suppress nor correct the unknown causes of the illness, they are no cure for it, they merely may alleviate some of its symptoms. In the french language, such medicines are said to be symptomatic, which is somewhat of a misnomer. Indeed,

to say that neuroleptics (or antidepressors) act on symptoms is but one more fiction.

In fact, although the pharmacological properties of these medicines are quite well-known (we know their synaptic targets on neurons and how they act there), we know almost nothing about the far reaching consequences of their local actions as they are propagated in the maze of the central nervous system. We have to bear in mind that

psychotropic drugs do not act on symptoms, they act on neurons.

Quite frequently (sometimes) but not always, signs and symptoms of the illness can be favorably influenced by these drugs, but when this happens, it is in a probably very roundabout, complex and yet unknown way. There is yet no known way to make sure that those very neurons are targeted which indeed should be, because we don't know them for sure. We can be quite certain, however, that other neurons will be influenced as well which should not, although we know some of these. Psychiatrists then talk about side effects of the treatments, a reminder of the collateral damage of military parlance which might seem more appropriate here than on the battle fields.

To say that more recent neuroleptics, the "atypical ones", those of "the second generation" are more efficient (better) and have less side effects than previous ones is a fiction.

Every year, new neuroleptics are synthetized and marketed. They are called "atypical" neuroleptics because they differ from the older ones (the "typical" ones) by different affinities for their targets (receptors of synaptic transmission on neuron membranes); they differ by what is called their pharmacological profile. When "typical" (first generation) neuroleptics were the first to be used in the years 1950, they were directed mainly against dopamine receptors (D1/D2). They were given in much higher dosages than today, which entailed the development of signs of the Parkinson syndrome. The pioneering psychiatrists who first used these drugs erroneously thought that these signs were a prerequisite for effectiveness of treatment. Since then, numerous other neuroleptics were synthetized (directed at dopamine but also at serotonine receptors, among others). With time, it was gradually realized that lower dosages of neuroleptics could be quite effective and extrapyramidal side effects (the Parkinson syndrome) were not necessary to alleviate psychotic symptoms. More recent neuroleptics could now benefit from this knowledge as soon as they were developed. Minimal effective amounts are now the rule for all neuroleptics.

Bad reputation, resulting from both initial scant knowledge about their properties and poor usage, still clings to older, "typical" neuroleptics, although they are not actually supplanted by newer "atypical" neuroleptics. Psychiatry needed several decades of experience with these substances in order to become proficient in their use. Accurate knowledge about their correct usage is still far from being widespread enough among psychiatrists in our country. Bad reputation of the

neuroleptics has thus several causes:

first, initially, *too high amounts* were given, with inevitable and marked side effects (it still happens nowadays in this country!);

second, presently there is no sure way yet to predict with any degree of certainty whether a given neuroleptic will prove effective in a given ill person. Nor is it possible to predict with any accuracy how long will be needed waiting, either before a beneficial effect will become apparent or before deciding to renounce a particular neuroleptic. Unfortunately, in order to know, there is no other way than trying them out. As a frequent consequence of this, some psychiatrists believe that increasing the dosage might hasten, or improve (or both) the effect of the medication. That, of course, is both an error and the surest way to induce unwanted side effects and assure the bad reputation of a medication;

third, many patients complain of quite a number of symptoms, only some of these being completely or even only in part relieved by the medication. Partly improved patients may regain enough self- consciousness to become aware that they have problems. **Quite frequently and quite irresponsibly, many professionals feel it more expedient to explain away these problems by blaming the medication, rather than by acknowledging the role of the illness. By the same token, non compliance with the medication is frequently explained away by the aversion to side effects, whereas it usually and actually results from anosognosia** (already mentioned) **or ineffectiveness of the drug**. Intuitive psychological explanations of this kind always appeal to lay persons, because they have so "sensible" a feel to them. They are not sensible. They are just one more fiction.

Psychotherapy

Psychotherapies are the other obliged mainstay of "psychiatric care". Many among our psychiatrists still acknowledge only reluctantly or may even be averse to administering medication. Many of those who deign resorting to neuroleptics (or antidepressors) compare them to "crutches one has to bring oneself to use as an aid to psychotherapy". According to them, psychotherapy is the determining factor of psychiatric treatment. Since we are talking here more about psychoses than about neuroses, one may wonder on what solid evidence such opinions rely. The credit we will be ready to lend them probably will depend on both form and content of these psychotherapies, because this all-purpose word has assumed quite diverse meanings.

When trying to define the word psychotherapy, be it in the dictionary or from textbooks on psychology, only very fuzzy definitions are available. In very gross summary, psychotherapy is treatment by talking, by words. This being the case, what these words will be and to what use they will be put remains to be seen. In this country, anybody deeming oneself to be endowed with the required qualities of empathy and having a ready tongue to boot may set up as a psychotherapist if he wants to. The door is thus wide open to all more or less reliable or even harebrained so-called "therapies" (*and announced federal governmental measures to regulate the profession of psychotherapists in no way ensure that the content of the "therapies" should be more credible than before*).

Beneficial effects of psychotherapy on gravity of psychotic signs and symptoms, on the frequency of the aggravations (the relapses) of these illnesses are still another fiction, it is nothing else but wishful thinking.

Implementing psychotherapy in order to treat psychotic ill persons (afflicted with bipolar or schizophrenic disorders) is a nonsense which therapists refuse to acknowledge. They deny the actual existence of the very dysfunctions they claim fighting against, they ignore their features, they deny their seriousness. They pretend treating neurotic persons who are supposed to be able to get at their own problems by introspection and analysis, whose problems would be amenable to self-criticism and self-correction. That's not a mistake, that's a blunder!

For example, when **treating people afflicted with bipolar disorder,** they try, by talking to them, to let them acquire a "more positive" view of themselves, a view which would be closer to objective reality (at least as it is perceived and assessed by therapists). They treat patients as if believing that the depressive phase of the disorder should result from a "negative" judgement or, at the other extreme of the illness, as if the maniac phase of their disorder should be the consequence of an euphoric lack of judgment of oneself, of other persons and of events. If need be, talking for hours with these persons should thus be enough for changing their mind for the better... Don't they realize that they actually have it all the wrong way round?
All of us experience changes in mood: we all have our more or less marked "highs" and "lows". They may change overnight or last a few hours or a few days, they may depend on outside circumstances and surrounding events, or they may seem to have no immediately obvious cause whatsoever. Our judgement on things, on events, about ourself and other persons always filters through the looking glass of our mood. It cannot avoid becoming tinged with the color of the glass. Instead of staying clear and neutral, the filter may sometimes change to dark and cloudy, or it may at other times become clear and rosy. In healthy persons, however, these oscillations do not last nor do they reach such extremes where they would get stuck: either in depression, or at mania.
In persons affected by bipolar disorders, this pendulum of the mood has become faulty, poorly balanced; its swings are too easily elicited, both by trifling surrounding events and by inside (physiological) states. The swings also reach extremes where the pendulum gets stuck and may not come unstuck on its own. All talking therapists may try to induce the patient to change his mind/mood has to break through this altered filter of the mood. But mood pathologically altered doesn't allow to listen to rationality. Medication is required to restore the balance of the pendulum of mood.

Today, we know that "psychological causes" do not cause bipolar disorder. We should thus also realize that psychotherapeutic lengthy talking can provide no prevention against the outbreak of the next "psychotic episode" of bipolar disorder either, should it prove a depressive phase or a manic fit.

When **addressing people afflicted with schizophrenic disorders**, most of our therapists ascribe to their patients their own beliefs and wishes, they seem to be convinced that they can imagine what happens in the head of their patients. They feel sure that they can think the "right" thoughts in their place, they believe that they can feel the right feelings on their behalf. In brief: they feel able to put themselves inside the head of their charges.
They seem to forget that numerous patients do not speak the common language anymore and that there is no translation dictionary available. Knowing what's going on in the head of other well-being, healthy persons is never a sure thing for anyone. Pretending to know their thoughts, feelings and desires when these other persons are mentally ill, when these ill persons obviously do not function in the same way that we do, when these ill persons seem no more able to quite "understand" themselves, how should we explain such extraordinary feat? The most likely explanation which immediately comes to mind is that numerous therapists think themselves to be God (*by the way, such interpretation tallies very well with the behavior evinced by numerous among our psychiatrists towards families of ill persons*).

Some psychiatrists believe that they can teach "social skills" to patients afflicted with schizophrenia. They say that these skills should enable patients to go back to society (what they call "inclusion"). They seem to imply that most psychiatric problems of people with schizophrenia are the consequences of their inability to establish relations with other people, they would result from their "unproper" behavior in society. Once again, they have it all back to front! That's their illness which deprives these persons of some skills they are unaware both of needing and of lacking. They don't miss them. Trying to teach these skills despite (against) the illness, despite the fact that patients do not feel the need for them is totally unrealistic.
Moreover, teaching methods rely on operant conditioning, they work at the reflex level. Cognitive defects due to the illness deprive the ill persons of the abilities of, at any instant, anticipating continuously changing events and adapting to them. These abilities require another functional

level, higher than that of the reflexes.
A few reflex behaviors akin to those of puppets on a string are no substitute for the ability to anticipate events and situations, for planning, for considered assessment of consequences of one's own and of others' actions.
Although therapists claim that they only strive after the well-being of the mentally ill, one is inevitably led to suspect that psychotherapies for psychotic patients ("schizophrenics", "bipolar depressive") mainly aim at enabling the mentally ill to apparently behave in society in such a way that they won't attract notice, that they won't disturb (offend) other people. They don't aim at enabling them to live on their own as they would like to. It is believed that, by making them unconspicuous, "including" them into society would be easier. "Inclusion", i.e. employment and work thus becomes the recognized aim. As shown by statistics from official agencies for employment, however, it is obvious that inclusion of psychotic persons (in terms of employment) is pratically nil in this country.

Psychotherapies can't address neither causes nor mechanisms of the disorders they are supposed to fight against because we don't know them. Moreover, in order to be effective on the ill persons and on their illness, these methods can't avoid using precisely those very mental functions we know are altered or even absent. Thus, for the purpose in hand, therapists pretend the needed functions are intact, or they proceed with their therapies in exactly the same way they would when facing persons mentally healthy all the same.

What benefits may the ill persons expect gaining by the use of therapies and techniques resting on sophisms and begging the question?

In fact, implementing these therapies requires quite a better and more continuous supervision (more caretakers for longer periods) of the ill persons. The reported supposedly beneficial effect of psychotherapies on frequencies and durations of relapses (hospitalizations) of chronic psychotic patients may thus result, more likely, from these improvements in surroundings, rather than it should be due to the very nature or the actual contents of the psychotherapies on their own.

Psychotherapies have still another purpose, however, some kind of side effect. They are also aimed at the people around the ill persons (the family, the friends, etc.), they keep them busy and do much to take their mind off their worries by assigning them roles and tasks (that's also what most NGOs and associations promoting "mental health" are doing most of the time for their own members). They thus give our professionals of "mental health" the illusion that they make themselves useful though they are almost powerless against mental illness itself.
Psychotherapies possibly give families some hope and the strength needed to rally round their ill parents. The latter thus receive from psychotherapy some measure of help in a roundabout way, which is not to be despised, however (*any straw is worth groping at*).

From what has been said above, we may deduce what psychiatric care given in psychiatric facilities boils down to. It consists in the daily dispensing of medication to the patients, in keeping watch over them in order to prevent accidents, to ensure minimal hygiene, to abide by schedules accepted by society.
Since it is well known that idleness is the root of all evil, diverse "activities" may be organized under the labels of ergotherapy, psychotherapy, etc., according to locally available resources of caretakers. With a bit of luck, the one or other patient may happen to like the one or the other occupation. If it helps him/her bearing the symptoms of his/her disorder, then so much the better.

Available psychiatric care thus does not differ from that which could be found in any second-rate day-care centers for "normal" children. In the present instance, however, grown-ups seriously psychically handicaped are involved, not healthy children.

Our presently limited scientific knowledge about normal mental functions as well as about psychiatry, severely limits our means for the struggle against psychotic disorders. Although there is nothing to boast about in the present state of affairs, neither is there any reason to keep quiet

about it, there is no excuse for letting people believe that all is done that could and should be. The problem posed by chronic mental disorders - and those encountered by their victims! - has always been present. In our society, there is much drivel about "Mental Health" (*you can hear the emphasis on those capital letters*) but zealots (both professional experts and self-anointed ones) of this very remarkable entity never were able to credibly nor usefully define its content, its true meaning. On the other hand, genuinely mentally ill persons ("psychotics") are only rarely mentioned. So-called official mental health experts would seem to prefer forgetting these ill persons, in all probability because they don't know (and possibly they don't want to know) what they should do with them, they prefer ignoring their true characteristics and their actual problems. Accordingly, they don't actively look for practically attainable, humanely acceptable solutions which would make life a bit easier to bear for them and those surrounding them.

We should never forget that denying actual problems or ignoring them never helps solving them, nor can they be solved by substituting fictions for them.

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BASIC PROBLEMS

The majority of our belgian french speaking psychiatrists don't seem to be interested in the structure (the architecture), in the mechanisms and in the workings of the brain. Quite a number if not most of them seem to be interested only in the consequences and in the visible outward signs of these workings. Thus, for want of available solid knowledge, they ascribe to these outward signs origins and mechanisms of production purely imaginary and untestable, which are products and constructs of their own imagination, of their own fantasy. This has been aptly dubbed the brainless psychiatry, a perfect example of unscientific or even of anti-scientific thought processes.

Explanatory theories, constructed under such circumstances in order to justify psychiatric diagnoses as well as psychotherapies implemented for treating mental illnesses, are not supported by any solid scientific experimental evidence. They are unverifiable assertions. The idea is widely held by lay persons and the public at large, that the higher such theories are piled up into bodies of doctrines more or less elaborate according to this or that psychiatric "school" or clique, the more impressive they would be, the more they should be plausible and the more they should be "valid". Unfortunately, they are quite mistaken. Such constructs are, so to speak, nothing more than theologies and exegetics on texts by intuitive theorists or by their followers, they could (*and indeed they should*) be compared to revealed religious truths and beliefs. They take into account only authoritative arguments, they are gospel according to Freud or to Lacan, etc., etc., but supporting scientific evidence is in fact always hopelessly lacking, despite numerous and usually vociferous claims to the contrary. Since they are not testable, these so-called theories are thus not even theories, they are mere constructs, fictions, fantasies. They are anything you wish to name them, but they are not science.

Practitioners of psychiatry should benefit from important extenuating circumstances, however.

One of these is the unique complexity of the human brain, which was already mentioned elsewhere on this website. Nobody can foresee how long neuroscientists will need in order to decipher the intricacies of the brain machine. No wonder that many psychiatrists should envision that task as a daunting one and would prefer relying on ready-made so-called "explanations" already available today...

Let us next remind the forgetful of the absence, in the animal, of language, of conscience and of the ability for abstraction: all these abilities (*at least at a level of development such as found in our species*) are features of only the human brain. Their absence in animals rules out the possibility to devise experimental animal models of human psychoses. Basic scientific research such as that done in other branches of biology and medicine thus simply cannot be implemented in psychiatry. We have to be satisfied with a purely clinical psychiatric research on humans. We have to wait for and to rely on serendipity for results.

Such features and constraints explain why progress in psychiatry is so slow (*Henri Laborit, a french neurosurgeon - not a psychiatrist - was first responsible for the interest in neuroleptics in the years **1950**, pharmacologists and psychiatrists followed in his footsteps. It was an australian psychiatrist indeed [John Cade] who discovered in **1949** (!) the effects of lithium salts on symptoms of depression, but it was by mistake and for the wrong reasons*). (*Incidentally, this exceedingly slow progress of research due to the absence of animal models should be a matter of thought for unconditional contenders of biological research and experimenting on animals*).

Lastly, one cannot emphasize enough the import of a direct and obvious consequence of our ignorance about causes and mechanisms of mental illnesses, although people who know this generally keep silent about it.

Whatever treatment would be chosen, be it "psychotherapy" or medication, be it a combination of both, or even when any treatments are refrained from, the course of action decided on cannot but constitute a disguised form of experimenting on the human

(*vivisection going on unacknowledged*) which, moreover, is conducted in a very poor and very unscientific way.

Theoretical underpinnings of most present treatments are usually untestable. These treatments merely reflect current prevailing ideas, beliefs and ideologies. Therefore, their use should always be under permanent, close critical scrutiny (*quite frequently, however, they are not at all*).

Other everyday problems arise which may be thought of as very commonplace. They are not less basic than the previous ones, however. They result from features specific of mental disorders and reflect our still too scanty knowledge about the functioning of our brain.
On this website, differences between mental disorders and so-called "somatic" diseases were already emphasized over and over again. The latter come to the fore through both material signs and symptoms, whereas the former produce symptoms only (*but lay persons - and numerous psychiatrists - use both words as if they were equivalent, which they are not*).
For physicians, symptoms are what the patients complain about, **symptoms** are the reasons why patients go to the doctor (feelings of tiredness, loss of appetite, poor sleep, various aches and sores, etc.,) whereas **signs** are what the doctor can observe and measure objectively (loss of weight or weight excess, unusual pallor, abnormal heart rythm, etc.)

Quite frequently, psychotic patients (schizophrenics, unipolar or bipolar depressive, for example) will not spontaneously go (i.e. on their own) to consult the doctor, because they are not able to interpret their **symptoms** as resulting from their own mental state. As a consequence, usually it's the people round about the patients whose curiosity is aroused by the peculiar ways of their ill relatives: their strange ways of incoherent talking, their inconsistent or unproper behaviour. These, indeed, are the **signs** of mental disorders. Contrary to signs of "physical" illnesses, which may be seen, "touched" and, so to speak, wheighed at any moment, signs due to mental disorders are immaterial and the very far and indirect consequences of their deep biological, material causes. They also vary unpredictably with time. Their degree of "anomaly", i.e. their significance for the illness can be appreciated only with time (*unpredictable outbursts and fits of variable, apparently random duration and intensity according to the moment and circumstances*).

As a consequence, deciding whether someone actually is afflicted with a severe chronic mental disorder would require that this person should be maintained under close, continuous and attentive observation for some length of time, the duration of which could not be predicted with any certainty. Practically, this could be achieved only through staying in a clinic or a hospital, possibly for several weeks!
Who is the person who would agree on going through such long stay in hospital, on the mere assumption that he/she might develop schizophrenia, while he/she wouldn't - couldn't believe it?
Who is the psychiatrist who would trust his own clinical intuition enough daring to propose such long stay in hospital to a patient both incredulous and terrorized by the prospect of an impending incurable illness, whereas developing a psychotic episode during this stay - which would constitute the only solid proof of the validity of the diagnosis - could in no way be ascertained beforehand?
It is thus no great wonder if numerous mentally ill patients went through very long and chaotic experiences before their illness was eventually recognized and the appropriate treatment was eventually prescribed (***it still happens today!***)

How are we to reconcile the fact that, necessarily, diagnosis is arrived at by hindsight, with well-meaning but unrealistic advices that treatment should be as precocious as possible (*advices based on statistical evidence open to question as well*)?
How are we to choose between keeping up a beneficial treatment or discontinuing it for fear of possible late neurological bad consequences, how are we to decide between accepting the drawbacks of the medication or rejecting the medication, thereby risking a possible but unpredictable relapse?
Today, nobody can satisfactorily (*i.e. based on reliable and conclusive evidence*) answer these questions despite their paramount importance.

Still another basic problem is not acknowledged, although it is staring all of us in the face. There are those whose profession would imply that they permanently should bear the hard ***facts*** in mind, that they should remind us of them and explain them to us in order that we might be able to adapt to them. That's the last thing most of them would do, however. Indeed, to do so would force them to look at themselves and at their own role from a point of view quite different from their usual one, it would force some unusual humility upon them. This is something you would find exceedingly difficult to achieve when so many people expect from you that you should perform miracles. Should you risk openly disappointing your customers? Should you clearly lay bare the well-known laws of probabilities which apply here as well as anywhere else?

Let us say it here once more: all what we know about psychoses, all what we are told of chronic mental "illnesses" are generalizations drawn from hundreds and thousands of individual cases, gathered and regrouped over tens of years and classified by rather disputable and arbitrary rules (*which also changed over the years!*): statistics were calculated from such figures, of course afterwards, with margins of error quite larger and "fuzzier" than in any other field ever under investigation (*due to the nature of the data*).

In national and other - public or private - lotteries, as well the numbers of existing tickets as the numbers of winning tickets drawn are well-defined and known in advance. Laws of probabilities thus let us predict quite precisely how many winning tickets bearing this or that given denomination (figures) will be drawn from the whole lot. This notwithstanding, what may the owner of a single ticket predict and expect? He may say that he has this or that percentage of chances for winning, which merely means that, if he had bought one hundred tickets, he could reasonably predict, out of his hundred tickets, the number of winning ones he most probably would own. He couldn't tell which ones he should keep, which ones he could discard, however. In order to know that, he would have to wait the results of the drawing.

One could say that every mental illness also is some sort of very bad "winning" ticket drawn from the lottery of fate. Figures on "tickets" such as those are far less legible than those printed on tickets from classical lotteries devised by man. They were defined by psychiatrists who, retrospectively and for years, counted numerous persons mentally ill and their various symptoms and signs, psychiatrists who more or less accurately recounted personal histories of individual patients.
This enabled them to divide mental illnesses into several more or less numerous categories, according to the individual symptoms and signs, the evolution and the outcome of the illness in every individual case.

Probability laws for this specific lottery are the same as those prevailing in any other one, however: whereas we know ***statistically*** (*and in retrospect!*) the general features of mental illnesses as a whole, it is still not possible to predict, for a given individual, an ill person, what will be the outcome of his/her personal situation, it is not yet possible to say beforehand what will prove to be the best treatment for him/her nor to predict its degree of effectiveness.

But what does every ill person want to know above anything else? He/she wants to know about what is to happen with him/herself. He/she wants to know something about his/her own, ***personal fate***. Statistics are no answer of personal significance to him/her! This cannot be helped yet.

Whereas it is now possible to predict the outcome of many diseases with a high or at least reasonable degree of accuracy even in individual cases, this is not yet possible when dealing with chronic psychotic mental disorders. We should know this and be prepared to face it.

Giving up reason for lack of knowledge

"If you are'nt the culprit, then your brother is."
Jean de La Fontaine: The wolf and the lamb.

We live in the 21th century. At least, that's what they tell us. We believe in scientific and technical progress, and most of us in western societies appreciate their benefits and the comforts they provide. Most of the time, we aren't even aware that we all use the spin-off of "science", that we all take advantage of its consequences in one way or another. Many people longing for "good old times" don't even realize that they couldn't dispense with these comforts any more.

Most of us think of themselves as acting and behaving in a logical and rational way in their everyday life and they believe that to be true. Some of us even claim that they are rationalists and, quite obviously, they are convinced of it.
From time immemorial, we are the heirs of uncountable lines of thinkers, philosophers, intellectuals and scientists. As a rule in all western countries, the educational system - i.e. going to school - endeavours to provide all with access to the means and techniques, in short to pass on the fully tested knowledge thus gained by our forebears. Teaching and education early on in our life enable us to efficiently make use of our brain abilities and, eventually, to pass on our knowledge to our descent, while possibly somewhat enhancing it with every new generation.

Known frontiers of the universe have been expanded. Man has walked on the moon and has begun exploring space. Every day, additional secrets of matter and of energy are uncovered. Researchers recently achieved deciphering the human genetic code, thus paving the way for numerous medical advances. New approaches and treatments are on their way, which were'nt even dreamed of only few years ago. When untimely wear and tear or decay, accident or illness jeopardize the functioning of, among other organs, the kidneys, the heart, the liver or the lungs, replacing these damaged organs with grafts from human donors has become possible, thus saving or prolonging lives which hitherto had been thought to be condemned within a short time.

All these technical feats and still many more, all our knowledge about the world surrounding us, as well as the knowledge about ourselves who are part of this world, all result from implementing the "scientific method". In simpler words, they result from **applying logic and reason** (***the rational method***) to help satisfying our curiosity and our inborn need to understand things and events. From results arrived at, we may feel with some confidence that **the rational method has demonstrated its power, its reliability and its efficiency. We even may say that it is the only known method available to man which may lay such claim**.

With the help of *the rational method*, we presently know the causes of numerous infectious diseases, their ways of spreading, the mechanisms of their actions, and this knowledge provides us with the means to fight them successfully. Man even succeeded in completely rooting out several of the most dreaded diseases. In our advanced countries nowadays, nobody would still cling to ancient beliefs according to which such now sporadic or even disappeared diseases were some kind of God's scourge - plague, cholera, etc. - sent to punish mankind for its sins.

Thanks to the *rational method*, every day we add to our knowledge of the structure and the workings of our body (of all our organs). Our understanding of the origins and of the mechanisms of numerous diseases which interfere with the functioning of our body is steadily growing. This knowledge and this understanding enable us to fight diseases with results which frequently are totally successful (i.e. recovery) or perhaps may sometimes prove only partially so (they provide significant mitigation of symptoms, however), but the outcomes are almost always predictable. Nowadays, such well-known diseases are'nt any more thought of as resulting from someone's fault, even when these diseases are very serious ones such as, for example, some cancers which still resist the most recent of treatments.

Yet, circumstances still happen today when people presumed to be responsible for diseases are

sought after and wrongly pointed out as the guilty party. The disease called osteogenesis imperfecta (brittle bone disease) is a good example well known by many lay persons. In individuals affected with this disease of genetic origin, bone formation does not proceed normally but leads to the development of exceedingly fragile and brittle bones. As a consequence, multiple bone fractures occur without apparent cause. Such fractures occur already in infancy and childhood. Not long ago, ***well-meaning but ignorant*** teachers, nursery nurses, social workers and even doctors, after observing such fractures, accused parents of beating their children (*some parents were even wrongly given prison sentences, their children were taken away from them*).

In this especially illustrative example, the origin of the charges, the source of the stigma is instantly obvious: quite evidently, it is the widely shared ignorance about the disease which is responsible for the accusations, for the charges of and the beliefs in ill-treatment. First, generally accepted but wrong ideas and opinions make up for ignorance; second, the need for scapegoats usually follows: somehow there has to be a fault - the fractures are solid evidence of it, aren't they? - , hence there also has to be a guilty party lurking somewhere which should be flushed out (*and some parents beat their children, isn't that current knowledge?*)
Such suspicion is immediate, especially in times when ill-treatments of children are so much advertised in media and in the press. And in this instance, aren't the parents the first obvious and available suspects? Since they are those who have most opportunities and the means to commit the crime in the first place, fictitious but apparently plausible grounds for misbehavio[u]r or mischief would be readily thought up and ascribed to them. Later on, this ignorance about the actual causes of the fractures is also likely to incite some people to stigmatize parents in the eyes of their own children, because ignorance and stupidity quite often belong together. Distress will then add itself to pain.

Later still, children themselves said to have been ill-treated may even, when grown-up, inherit the bad reputation of their parents (*skeletal deformities may sill be present and visible to breed malevolence of others towards them*), because ignorance and malicious gossip also frequently go hand in hand. It would be no great wonder then if the fantasy of ignorant people were to attribute to them all kinds of supposed wrongdoings.
Benevolent people may retort that I gave a caricatured description, because I chose as an example the brittle bone disease, which is a quite uncommon condition still ignored by many. Because ways of thinking and behavio[u]rs evoked about this disease's consequences are rooted in ignorance and superstition, they may be said to verge on obscurantism. This would support believing that they surely are quite the exception in our enlighted times!
If that's also what you think, then I am afraid to tell you that you are mistaken. False ideas such as those evoked above are much more frequent than you would suspect, they even may be held by a non negligible number of educated people who may claim they know what is "science" because, when they were students, they attended a few lectures about "science".
Such kinds of witch hunt exist today because they reflect a very common cast of mind which outlived the alledgedly "dark" Middle ages and can still be found today, even among very respectable members of the elite.

Chronic mental disorders (serious psychotic mental disorders) are much more common than "brittle bone disease". Some epidemiologists evaluate their frequency at 3-5% of all people all over the world (this is debatable, but that's still another story; here, let us tentatively accept these figures).
Neither causes nor mechanisms of mental disorders are known at present, whatever so-called experts (some of them doctors!) may claim and try to convince of miscellaneous fallacies the public at large (*as well as the ill persons themselves!*). Both this ***ignorance and the innate need of the human species for explanations*** of any phenomenon that it runs into lead to imagine and to think up causes and hypothetical mechanisms of these disorders. Such fallacies entail witch hunts: when unusual phenomena or unproper behavio[u]r are witnessed, people immediately, automatically suppose that some error has been made or that a fault has been committed which should require someone to blame or a guilty party. Thus let us search for him/her and flush them out!

Every time when we are confronted with a disorder about which we know next to nothing as far as its origins and mechanisms are concerned, how come that always people are coming up with the contention that ***necessarily, somebody should exist somewhere who should be held responsible for it?***

This claim notwithstanding, nobody in his right mind would say that somebody should be held responsible, for example for **diabetes**, a disease which can be treated effectively although no actual cure is yet available. Nobody questions the biological nature of diabetes and, despite the obvious (*but possibly because of it!*), persons afflicted with diabetes don't think they are responsible for it, neither do they feel guilty of it nor do they blame others for some "fault" they would have been responsible for to "cause" the disease.
The same could be said in relation with **multiple sclerosis**, a disease which damages the sheats protecting nerve cell processes everywhere in the central nervous system. Although causes of this disease are still at issue and no truly satisfactory treatment (cure) is yet available, the biological nature of multiple sclerosis is not in doubt. Nobody, however, would dare expressing the view (*thus risking being ridiculous*) that it should constitute a valid reason for holding its victims responsible for it!
Examples could be endlessly multiplied, illustrating the fact that "biology" in no way should be thought of as synonymous either of responsibility or of guilt, nor could these be attributed to the victims themselves or to others. But what's the use? Some people keep insisting on such view whatever you may try explaining to them... *perseverare diabolicum*...

Some people, however, - doctors among them! - in our french speaking countries, when talking about chronic mental disorders such as schizophrenia for example, say that "whereas biological theory allowed to take away some suffering from the parents, it also has at the same time transferred the burden of suffering onto others who suffer as well, i.e. the schizophrenics". Pending further information, every doctor should by now have learned that, as all other living beings, we exist and function only by and through biology. Would these dreamers care to explain, once and for all, what they mean by such preposterous oxymoron as a "**non biological disease**"?
Some of these thinkers claim that "according to the 'biological theory' [*of schizophrenia*], parents are not the cause of schizophrenia of their children; therefore, if the accusing finger of the psychiatrist should not any more be pointing at the parents, this however amounts to now pointing it at the [*ill*] children themselves".
Such nincompoops should be taught some good sense in order to avoid sticking out their finger and undiscriminatingly pointing it at anything and everything (*moreover, might that not be risky?*)
Where do they get this permanent obsession from, this need to point out people as being responsible for a mental disorder, or this need for finding them guilty of causing it? Are mental diseases necessarily and always **somebody's** fault? Why not **fate's** fault, for once?

The same people tell us that schizophrenia should result from "the meeting of a part of biology with a part of environment" (*whatever that means*), a fact which "would now be generally acknowledged" (*so they would us to believe*). Quite obviously, those who utter such balderdash don't understand what they are talking about. They are merely demonstrating that they don't know what is biology, that they don't understand the interplay of biology and environment any better. They mix up genetics with biology as a whole whereas genetics are only a small part of biology. They set what they think is biology - and actually is genetics - against environment, and they don't realize that environment without biology makes no sense at all.

Some french speaking doctors believe that "DNA predestines the patient for what he is going to live through and somehow makes him responsible for his disease". Everybody, and doctors in the very first place should know the meaning of genes (and DNA). As stated by R. Plomin *et al.* (Behavioral Genetics, Freeman & Co., New York 3rd ed. 1997, p. 278), "***Genes are not destiny. Genetic effects represent probabilistic propensities, not predetermined programming***".
Doctors should explain that to lay persons and to their patients (*of course, in order to be able to do so, they should have learned about it, they should understand it themselves, they should not*

have forgotten all about it since their stay at medical school...)

Moreover, whoever could maintain such nonsense as that the DNA of genes would make its bearer/owner ***responsible*** for, among others, his height, the color of his eyes, the size and shape of his nose, and even his ideas or his opinions would be predestined as well?
Weren't such ideas and views already expressed by XIXth and XXth century woolly-minded and dangerous ideologists and by dictators of evil memory to justify, among others, genocides, extermination of whole populations on an industrial scale, goulags etc. ?
All that has been written so far should convince you that, far from pointing at a new guilty party which would substitute for an older one, on the contrary the biological "theory" of mental disorders has relieved all parties by giving up the disastrous construct (*not a theory!*) of a fault to be ascribed to someone as the cause of the illness.
Some rather arrogant "professionals" nevertheless still cling to such ideas, they suggest that parents of children afflicted with mental disorders should examine their conscience (*in order to find out what fault they committed to bring about the illness of their child[ren]*).
Such self appointed "professionals" have a short memory indeed. Shouldn't they first reappraise their own behavio[u]r - not so long ago - based on the nefarious theories of B. Bettelheim about autism? Don't they know what has become of these "theories" today and doesn't that give them food for thought?

Systematic confusions of correlation with relation of causes and effects were already exposed in several instances elsewhere on this website. Such errors were reviewed and debunked in a masterly manner by the late Dr Petr Skrabanek in his book entitled "Follies and Fallacies in Medicine" (*item n° 11 under our heading "Lectures" [books]*). It is one of the sophisms which is frequently expressed by our psychologists and by our psychiatrists. I am convinced that a large part of the ill persons' hardships and of those round about them results from the stubborn will to spread and to enhance this sophism in mental health circles as well as in the public at large.
It is not my task to unearth the deep reasons why mental health professionals persist in holding such views. If I were to try, I would lay myself open to precisely the same criticisms I aim at numerous "psy" workers: ascribing to the patients and to the members of their families motives and intentions resting on no solid evidence, but which they actually get only from their own, rather twisted imagination. Thus I leave to others the task of finding out why so may people claiming to be "professionals" persistently stick to such unsupported and phony notions.

Disagreements, divergences in opinions, contradictory aspirations, conflicts and even confrontations arising within families between members of successive generations were known from the beginning of time. They always constituted an inexhaustible source of inspiration for novels and all kinds of fiction. Famous epic stories from antiquity mentioning them have come down to us. Life nowadays also has its numerous little and short-lived family spats and arguments, or more seldom true quarrels followed by enduring hurt feelings also may arise. A large majority of these arguments are usually rapidly settled without causing a lot of fuss or getting printed on the front page of newspapers, nor do they cause disease. If things were different, then we may bet that the social entity named family should have vanished from earth, completely and a long time ago!
Nobody seems to realize that conflicts between generations are the result of an established and unmodifiable fact of life that stares them in the face: although children age, grow up and become adults, parents and children never are simultaneously the same age, which means that they never have the same experience of life, the same outlook on all things and on life ***at the same time***.
Parents and children just have to make the best of this situation. Since this has always been so, one should acknowledge that, by and large, both children and parents seem to manage not too badly.

Indeed, a vast majority of families are spared the development of a chronic psychotic mental disorder in one of their members, even when some "violence" is present between grown-ups and their children. Even when a mental disorder develops in one child, its siblings are only very rarely

affected, although they live in the same family environment. Conversely, even in well-to-do families where every member lives on the best terms with all the others, schizophrenia nevertheless may develop in one teenager whereas the other children are spared.

When the mental disorder breaks out, in most instances the ill person him/herself is not aware of it. Taken singly, the various signs and symptoms of the mental disease are never specific. Hence, parents and people around the ill person cannot immediately recognize these signs and symptoms for what they actually are: the signs of a mental disorder. Lack of understanding and misunderstandings ensue and become the rule. Necessarily, ***because of the disease going on unrecognized***, the ill person and the other members of the family are continuously at cross-purposes. All justified and unjustified grievances will pile up on both sides because nobody is realizing that the source of the lack of understanding lies in the ignored mental disorder.

Sooner or later the atmosphere at home deteriorates too much and most if not all members of the family can't stand it any more. The behavio[u]r of the ill person may give cause to worry about his "physical" health. All sleep poorly or not at all and eventually end up in dire need of rest. Family life is seriously disturbed, which also may tell on the efficiency at work. Then, faced with a lot of questions they are unable to answer, relatives eventually call on a psychiatrist.

In Belgium, to get your ill relative examined by a psychiatrist is no easy task. This specialist almost never accepts visiting patients at home, patients have to go on their own and of their own accord to his consulting room (*for most of our psychiatrists, this would be evidence of the patient's will to undergo therapy which, according to them, is of the essence, a prerequisite for the treatment to succeed*).
Quite frequently, however, convincing the ill person to consult a psychiatrist is anything but a rest cure. Weeks of not necessarily very peaceful discussions and trials may be needed in order to bring him/her to go to the doctor. On the other hand, it is not less difficult to convince the psychiatrist to listen to and hear out both the parents and their ill son/daughter, out of as well as in his/her presence. Unfortunately, the latter is not yet the way of most of our belgian psychiatrists.

When, at last, the psychiatrist meets one party - and, sometimes perhaps, he may meet the others as well - , weeks or even months may have passed with their share of misunderstandings, of worry, of anguish. The ill person has withdrawn into his/her illness, he/she nurses his/her fantasies or delusions and blames all around him/her as well as the world at large for the ills and evils that plague him/her.
As for the other members of the family, their nerves are badly shaken, they are exhausted, the smallest unimportant annoyance they happen across may trigger them off to blow their tops.

When called on for the first time, doctors or psychiatrists witnessing this situation see only the outcome of a process whose onset and development they did not live through themselves and could of course not observe. This notwithstanding and on the only basis of their intuition, their "clinical expertise", their psychology, their feeling or whatever (*you name it*), they may soon decide (after some conversation lasting at most one hour but often more likely less) that parents are highly nevrotic persons and that their behavio[u]r is generating suffering (*i.e., their behavio[u]r is iatrogenic, in other words they are the cause of the disease*).
That will clinch the case: guilty parties were found and exposed as required, all else will follow naturally from the psychiatrists' apriorisms which I dare you to question.

Isn't that an especially illuminating example of the fallacy that the association in time of two phenomena should mean that one phenomenon should, ***necessarily***, be the cause of the other one (*although you could find lots of other examples of the same brand of error in reports of the W.H.O., they are errors all the same!*)

Any sensible person should realize that signs and symptoms of mental illness in one member of the family can not, at first (at the onset) be understood by his/her relatives, they are unsettling - to say the least - and they may even be frightening. They are thus very likely to generate a parody of neurosis in the other members who are confronted with these signs for days on end. That's some

psychiatrists who dream up things the wrong way around and would us swallowing such nonsense!

One of the most fundamental principles of justice in democracies is the presumption of innocence. On the contrary, should most of our psychiatrists and many psychotherapies adopt, in a systematic way, the idea of presumption of guilt, reminding us of totalitarian regimes?

Many of our french speaking psychiatrists and psychologists seem to be unacquainted or at odds with simple, obvious and logical explanations of events (i.e. sensible explanations). They seem to prefer confusing causes with effects, mixing up consequences and causes in an absurd whirl of reasons, motives, alledged results, etc., which one of them even has dubbed the "circular causality"! Shouldn't such way of "reasoning" and of doing things be felt as an extraordinary demonstration of

denying or perverting reason, a mental torture on the pretence of treatment and care, taking up a perpetual stance of suspicion, some kind of a psychiatrist's paranoia?

DOES COINING A NEW NAME BRING A NEW THING INTO EXISTENCE?
DOES DELETING A NAME CAUSE THE THING IT NAMES TO GO OUT EXISTENCE?

DESCRIBING PHENOMENA WHOSE NATURE NOR CAUSES ARE KNOWN, WITH WORDS WHOSE MEANINGS ARE NOT CLEARLY DEFINED, ISN'T THAT TALKING A LOT OF HOT AIR?

"*What's in a name? that which we call a rose*
by any other name would smell as sweet."
William Shakespeare: Romeo and Juliet, II, ii, 1-2

"*Man is by nature a metaphysicist and filled with pride. He could believe that the ideas made up by his mind, which would suit his feelings, would also represent reality. ...*
...To sum up, we should realize that the words we use to express the phenomena whose causes we don't know are nothing in themselves, and that from the moment we grant them any value for criticism or in debates, we give up experimental evidence and fall into scholasticism ...
...In science, the word criticism is not synonymous with disparagement; criticising means looking for truth by separating the true from the false, to tell apart good and bad."
Claude Bernard: Introduction to the study of experimental medicine. Paris 1865

The BBC recently reported that academics, psychologists and psychiatrists in Great Britain had engaged in controversies about the significance and the usefulness of the term "schizophrenia" for the diagnosis of what should be recognized as some rather arbitrary rag-bag of ill-defined psychotic illnesses. Some of them united to launch a campaign to scrap the term "schizophrenia": **C**ampaign to **A**bolish the **S**chizophrenia **L**abel (CASTLE). Others think that, although the term is not accurate, it is nevertheless useful and should be retained, at least provisionally until a better name is found.*(but why would it be better?)*.
(*see http://news.bbc.co.uk/2/hi/health/6033013.stm and http://www.schizophrenia.com/sznews/archives/004045.html*)

Such fruitless discussions are far from new, but psychiatrists, psychologists and psychanalysts from many countries don't seem ever becoming weary of them.
Among these professionals of mental health are those who favor discarding the term because "the concept is scientifically meaningless" and groups together a whole range of different problems under one label, which may be ultimately damaging to patients: because it may encourage the same "biomedical" treatments (drugs) for all to the detriment of individualized psychological help (psychotherapies?).
Some of the experts believe that it should be possible (and more efficient) to target drugs and psychological treatments on specific signs and symptoms as they are found in individual patients. *(Convincing evidence in support of this latter claim is still lacking, however, and, despite frequent statements to the contrary, there aren't yet any drug nor psychological treatments which would "target specific symptoms" of schizophrenia, for the quite simple and obvious reason that the causes and the mechanisms of the symptoms are unknown. Considering for how long such attempts have been claimed, successful therapeutic results, if there had been any, surely should have received a lot of enthusiastic publicity! Did we actually hear of it?)*

Other advocates of scrapping the name "schizophrenia" think, falsely, that this label both is somehow worsening the illness and the source, in the public at large, of numerous disparaging ideas about the ill persons: ideas of violence (which are indeed false), of dangerousness (also false), unpredictability (which is true), inability to recover (which is true when people think that recovery should mean being cured), a constant and lifelong need of medication (true), the inability

to work (which may be either true or false, depending on the degree of severity of the illness). They say that the label is stigmatizing. That is an easy way to distort the truth: that's not the label which is stigmatizing, that's the behavioral consequences of the illness that are so. Such an ingrained reproving attitude generally prevails in the public, quite automatically, also towards people in good health if they happen to behave in the same "unproper" ways as mentally ill persons may do, but of course, the latter do it unwittingly.
There are also diehard professionals (guess who?) who still stubbornly cling to the belief that child abuse is the primary cause of schizophrenia, although this ideology has been disproved since a long time and has nowadays become rather outmoded.

I find it somewhat difficult to understand how one reasonably might hope that discarding the term "schizophrenia" should in any way improve the public's impressions or the professionals' knowledge of these illnesses regrouped under this label, since neither does it explain anything, nor does it provide any clue for a more rational treatment. It would not in any way entail the extinction of the illnesses, and it could not any more ensure a better health of the ill persons. Contrary to what some so-called experts seem to believe and to what they seemingly would have us believing, burying one's head in the sand never was a successful policy, and discarding a name never abolished its target, nor did the word's deletion change the properties of the thing it stood for.
Quite obviously, Shakespeare was a much more astute psychologist than many of our present day mental health professionals seem to be, and in his wake, today I would like to say: "*What's in a name? Those whom they call schizophrenics, by any other name would not fare any better.*"

Another bunch of experts would prefer to keep the name of "schizophrenia" for practical reasons; according to them, the diagnosis of schizophrenia is at present the only available means to distinguish ill persons afflicted with this woolly syndrome from those persons afflicted with other psychiatric psychotic disorders (not less woolly), in order to provide them with the treatments best suited to their "case", to their "personal needs". Some of these therapists, however, would readily replace the "***unpleasant***" term "schizophrenia" with that of "dopamine dysregulation disorder" (is it "more pleasant"?) which they believe to "reflect more accurately" what is happening in the brain when someone is psychotic *(this assertion is debatable, however, and the name suggested as a suitable alternative for schizophrenia is not less of a rag-bag than that of schizophrenia itself)*.
As history has shown, other names (diagnoses) coined long ago by medicine and psychiatry, such as cretin, schizophrenic, idiot, oligophrenic, etc., etc. rather rapidly became insults in everyday lay language. In all likelihood, "dopamine dysregulation" would soon meet with the same fate.

When you think of it, you can't but wonder about what these hair splitting discussions may contribute to the knowledge of those mental disorders regrouped under the umbrella name of "schizophrenia". What does such never ending quibble actually contribute to the improvement of the treatments and of the fate of patients afflicted with "schizophrenia"?
Such fruitless discussions keep experts busy and happy, but meanwhile they forget one of their most important tasks: painstakingly researching the true biological causes and mechanisms of psychoses, and thus they don't help their patients as well as should be expected of them (I would like to say to them: *"You are sleeping, Brutus, while Rome is waiting in fetters";* Voltaire, *The death of Caesar, II, 2)*.

Moreover, by dint of always relying only on the sole power of words forming high-sounding sentences (though often devoid of any meaning), many professionals eventually forget that descriptions of things and phenomena made with these words are, necessarily, always incomplete and inaccurate. Words don't convey any idea of a perfume if you did'nt smell it before, because your nose doesn't use words; you can't "explain" with words a new perfume to anybody except to perfumers or to persons trained to the task of smelling (people with a cold or anosmia should abstain!).
Neither do words describe a piece of music to someone who doesn't listen to it or who never heard it before, and you can't force a person deaf from birth to imagine it, even by using sign language.

What was said above holds true for psychoses, which you can't describe nor "explain", except to those who, day in day out, live with a patient. These persons "understand" descriptions of the illness because, when they are told them or they read them, they feel themselves treading on familiar ground.
But some people, who sometimes deem themselves to be professional experts, do not like the descriptions of the illness made by relatives (since the latter are not acknowledged experts) and say they are simplistic, incomplete and inaccurate. Possibly, they get carried away by their hypertrophied imagination which prevails over their somewhat less well trained critical mind. They thus don't enough pay attention to the realities of lives which they do not live through themselves.

As a consequence, descriptions of "schizophrenia" made by others, which take into account only facts actually observed and sensibly refrain from unwarranted "psychological" interpretations disappoint the professionals' imagination. They can't acknowledge their value because they can't understand them: they listen (do they?) to words with their imagination, not to odo[u]rs with their nose.
If professionals actually wish to help patients afflicted with schizophrenia, they should try to live more side by side with them, they also should better control their own lively imagination and perhaps beware of it.

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