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.