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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