Agents of Change: The Person or the Pill?

by Dr. Francis McGivern

"Psychotherapeutic drugs have the power to remap the mental landscape" (Kramer, 1997, p.209), to make the mentally ill well again, to make those who would be otherwise inhibited outgoing, and to make those with low self-esteem re-evaluate themselves in a more positive light. From another paradigm, however, this 'power' can be construed as "the business of psychiatry [manifesting as] coercion, [and] not cure"(Szasz, 2007, p. xxiii).

Introduction

With the ever encroaching influence of psychopharmaceuticals upon our profession, it is incumbent upon us as ethical practitioners to begin to question both the level of healthy dialoguing that is taking place between the psychological and medical professions that ensures best practice for the service user, as well as the position we as a profession take in relation to what constitutes psychopathology or 'disorder'.

This paper endeavours to develop a framework for reflection upon these issues through exploration of each thesis posited by psychiatrists Peter Kramer and Thomas Szasz in their publications 'Listening to Prozac' and 'The Medicalization of Everyday Life' respectively. Although Kramer's book is now almost twenty years old, both publications nonetheless still have much to offer in provoking debate around the morality of medicalisation, and the prescription of drugs with the intent of transforming the 'self'.

First, the most obvious but perhaps most salient parallel between the two authors is the high regard each demonstrates towards the psychological wellbeing of the individual. Both also acknowledge the capacity an individual has for change. The divergence begins to occur when reflecting upon what or who is the *agent* of change.

The Power of the Pill

With the advent of the antidepressant drug Prozac towards the end of the 1980s, Kramer observed a substantial minority of his patients 'transforming' and becoming 'better than well'. On one of his earliest occasions to prescribe prozac in response to a patient's tendency toward melancholy and compulsiveness, Kramer noted improvement in the patient's level of creativity, vitality, optimism, procrastination, memory and concentration.

> *Altogether Sam became less bristling, had fewer rough edges…The style he had nurtured and defended for years now seemed not a part of him but an illness. What he had touted as independence of spirit was a biological tic (Kramer, 1997, p. x).*

Kramer cites another of his patients attending him during the introduction of prozac, who despite no longer displaying overt signs of depression at a clinically significant level, maintained a degree of fragility particularly with regard to romantic relationships. Two weeks after prescribing her prozac she reported no longer feeling weary but relaxed, more hopeful, energetic, confident, she was laughing more, felt more satisfied and assertive at work, and significantly she was no longer drawn to destructive relationships and was looking forward to dating again. Having experienced such a dramatic change in herself in such a short period of time, Kramer's patient

now believed that she had been depressed *all* of her life and for the first time was completely clear headed.

> *If her self destructiveness with men and her fragility at work disappeared in response to a biological treatment, they must be biologically encoded. Her biological constitution seems to have determined her social failures (Kramer, 1997, p.18).*

Psychotherapy over a period of time Kramer claims, would have facilitated both of these patients gaining insight into the influence of their early childhood experiences on how they related to others in adulthood. Prozac, however, not only appeared to bypass this therapeutic work but *altered* personality in a way that psychotherapy possibly could *never* do. This pharmacological 'self-actualisation' manifested itself so dramatically that Kramer questions whether the medication had in some way eradicated a 'false' self and replaced it with a 'true' self. Thus, 'cosmetic psychopharmacology', medicating often in the absence of a clinical presentation to improve aspects of personality, appears to be the central agent of change according to Kramer.

Demedicalisation and the Power within the Person

In contrast, Szasz (2007) strongly advocates an alternative viewpoint in which the individual himself is the only *real* agent of change by which he holds personal responsibility for how he thinks, feels, and behaves. He has choices and he consequently makes decisions independent of his neurobiological environment. Szasz asserts that the notion of a 'false' self is tantamount to a 'mentally ill' diagnosis, a 'disease' of the brain, the result of which deprives the individual of free will. Construing specific behaviours and personality traits that society disfavour – low mood, social anxiety, shyness, low self worth, poor interpersonal skills, pessimism, diverse human sexual appetites, delusions - within the parameters of the medical model and creates what Szasz describes as a medicalisation of everyday life. In short, medicalisation occurs whenever a problem or disorder is treated from a medical perspective. As a result, many habits, behaviours, and 'ways of being' once assumed to exist within the 'normal' spectrum have now been diagnosed as diseases, not because of scientific advancement as one might expect but rather in response to cultural, societal, and political influences.

A fundamental difference between the two authors is their view of 'mental illness'. Szasz believes that 'illness' or 'disease' in its purest form signifies an abnormal biological condition of the *body*. He offers the ideas of Oxford philosopher Gilbert Ryle who suggests that since the mind is not an object, like the body, it is erroneous to associate it with illness/disease. Moreover, the "diseased mind" or "mental illness" is a metaphor, but psychiatry has applied the term 'disease' and 'illness' *literally* to the workings of the mind. Szasz' thesis is that at autopsy, a diseased *brain* can be detected and observed but a 'diseased' *mind* cannot. Thus, rational deduction would suggest that it does not exist.

By exploring demedicalisation, that is, the opposite of medicalisation, one may develop a deeper appreciation for the paradoxical lack of medical rigour involved within this continuum. Until recently for example, masturbation and homosexuality were considered diseases (Szasz, 2007). That is, they were considered abnormal conditions that required medical intervention. Masturbation has been variously defined as a sin, an immoral weakness, and as an illness during the 19th century. However, it moved along the continuum towards demedicalisation following sexologists Masters and Johnson normalising masturbation as well as the Kinsey report finding that over ninety percent of men masturbated (Conrad, 2007).

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Despite private sexual conduct between consenting adult men being decriminalised in Britain in 1967, treatments to eradicate the 'condition' of homosexuality were most widespread during the 1960s and early 1970s. Homosexuality was removed from ICD-10 (international classification of diseases) in 1992 (Smith et al., 2004), not due to it having been

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'cured' out of existence but rather due to its demedicalisation. So something that was once classified as a mental illness or disease was abolished by psychiatry as a result of social pressure from the homosexual lobby rather than as a result of advancement in medicine.

Another example of the fluidity that appears to be in force along the medicalisation-demedicalisation continuum is the case of Graham Young, the 'Tea-Cup Murderer' whom, after poisoning several people was diagnosed initially with a mental illness and sent to Broadmoor. One psychiatrist offered a diagnosis of schizophrenia, whilst another offered a diagnosis of 'neurotically engendered psychopathic disorder' (Bowden, 1996). Poisoning several others on his release caused a re-evaluation of his conduct towards the demedicalised end of the continuum, being viewed now as a criminal rather than as a patient. He was convicted of multiple murders and sent to prison. Thus, if masturbation, homosexuality, schizophrenia or psychopathic disorder can be demedicalised, it stands to reason according to Szasz, that the existence of other diagnoses within ICD and DSM are questionable at best.

> *Whatever aspect of psychiatry psychiatrists claim is not medicalization, is not medicalization only if it deals with proven disease, in which case it belongs to neurology, neuroanatomy, neurophysiology, neurochemistry, neuropharmacology, neurosurgery, not psychiatry" (Szasz, 2007, p.xx).*

Biological Models of Psychological Disorder

Drawing attention again to the presentations of both Kramer's patients explored earlier, Szasz would presumably argue that 'treating' these individuals for obsessive-compulsive *disorder*, depression or any other mood *disorder*, or for interpersonal difficulties or challenges brought about by personality is "medicalization running amok" (Szasz, 2007, p.xxiii). However, Kramer might also argue that much of the evidence he cites in support of psychiatric intervention is gleaned from those working within pure or mainstream medicine who have an interest in human behaviour. Kindling and stress models of mood disorder for example, both have something to offer Kramer believes, in the understanding of the aetiology of not only major depression but near-normal depressive states also.

The kindling model is drawn from the work of neurosurgeons in the 1960s who "kindled" seizures in animals and found that less and less stimulation was required over time to generate them, to a point where they were happening spontaneously. Robert Post, a psychiatrist and biologist was interested in the similarities in presentation between these epileptic seizures in animals and the rapid-cycling of bipolar affective disorder in patients. As in kindled epilepsy, Post observed in his patients ever-decreasing time periods between episodes of mania and depression, increasing symptom severity, and significantly, decreasing levels of stimuli required over time for the onset of cycling to occur. Support for Post's model was strengthened with the superior response of bipolar patients to Tegretol, an anticonvulsant medication in comparison to the standard prescription lithium. Kramer's interest here leads him to hypothesize that trauma, the initial stimulus, causes specific parts of the brain to change at a cellular level and that this 'rewiring' in turn causes an ever-increasing sensitivity to external stimuli and consequently mental illness. This 'functional autonomy', that is, a response that lives on despite the cessation of the cause, Kramer claims makes a good argument for biological intervention. 'Stress hormones' such as epinephrine and cortisol have also been identified as possibly influencing the course of depression. A hormone produced in the adrenal glands, cortisol, similar to depression, has been found to affect mood, appetite, sleep, and physical movement. The substance in the brain responsible for releasing this hormone, corticotrophin-releasing factor has been found to be at an elevated level in stress studies using animals.

In essence, Kramer posits strong support in favour of a stress-depression model whereby individuals with low self-esteem, rejection-sensitivity, or even minor depression who experience further stressors are at great risk of developing a kind of 'kindled' disorder. Again, Kramer consequently supports early *preventative* biological intervention in order to avert the supposed inevitable danger to mental health.

> *Living with the sort of personality style that leads to repeated social failure may, beyond the pain caused to self and others, entail health risks (Kramer, 1997, p.125).*

Medicalisation from 'Above'

Surely, life's vicissitudes, its joys and sorrows, its traumas and triumphs make us who we are and equally who we are influences the course our life takes. Timidity, sensitivity, introversion, low self-esteem – all 'ways of being' that society is inconvenienced by. In fact Kramer (1997) himself expresses concerns about his sense that society strongly advocates one interpersonal style over others, having observed how his medicated patients now functioned better and crucially were more 'flexible'. Hyperthymia, a cluster of personality traits including optimism, drive, charisma, and confidence, could be viewed as a valuable asset in the world of business. Kramer reflects upon how attractive it could be to prescribe prozac ad hoc to an individual lacking these traits, in reaction to the competitive business world in which they operate. He describes a kind of 'diagnostic bracket creep', that is, defining less and less severe mood states as pathological, in order to meet both societal demands and fit the ever-expanding list of drugs the pharmaceutical industry produces that claim to iron out 'creases' within our personalities. Kramer's ethical dilemma here seems to reflect in part, one of the fundamental concerns Szasz has with psychiatry, that is, 'medicalisation from above'.

Szasz claims that 'medicalisation from above', from a position of power, is strongly rooted within psychiatry from its inception and functions primarily to maintain control within society and to meet economical, moral, and political interests. On reflecting upon what he calls 'pharmacologic self-actualisation', Kramer claims that *we* as a society "will have to decide how comfortable we are with using chemicals to modify personality in useful, attractive ways" (1997, p.15). Szasz' contention is that whilst Kramer denotes "we" to imply all members of society to include the lay person, psychiatry to this day promotes a power imbalance in which the lay person assumes the subordinate role of 'patient' who is denied the right to be consulted on any matter regarding his own welfare and completely bereft of any decision-making ability regarding the implications of psychopharmacological intervention (other than non-compliance).

Kramer regularly employs terminology such as 'illness', 'cure', and 'allowing' the patient, all words that arguably serve to maintain the inequitable dynamic that surrounds doctor and patient roles. He inadvertently offers an illustration of this power dynamic when he describes his realisation that a depressed college student patient to whom he prescribed an antidepressant, was anxious during the subsequent meeting not as a result of an amphetamine-like side effect but due to his fear of Kramer's reaction to learning he had chosen not to take the medication. Kramer had initially assumed that his patient's anxiety had a solely biological basis warranting additional pharmacotherapy in order to be suppressed. Whilst he offers alternative (psychoanalytic) explanations for the origins of the student's anxiety, this case example begs the question, is the patient's role to obey those in authority and the doctor's role to suppress the lived experience of the patient?

On reflecting upon power in relation to diagnoses, Kramer defines depression for example, in what could be regarded as quite a restrictive and uncompromising manner, that is, as "a relapsing and recurring illness" (1997, p.5)… and as "a progressive, probably lifelong disorder…[requiring]… early and prolonged intervention" (1997, p.114). Szasz contends that this description of depression as a mental illness is a recent

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phenomenon that has manifested in medical parlance as '*having depression*', whilst heretofore individuals merely '*felt*' depressed or '*were*' depressed. This point is echoed by authors Aine Tubridy a medical psychotherapist, and the late Michael Corry a psychiatrist, who call for depression to be viewed as a form of disillusionment due to particular unmet human needs rather than be classified in medical terms such as chemical, clinical, endogenous or even reactive (Corry & Tubridy, 2001). The psychiatric establishment's classification of alcoholism as a mental disease whilst other common addictions remain outside the realm of clinical nosology is yet another case in point according to Szasz of how psychiatry has developed considerable political pulling power. Thus, he sees the exclusion of addiction to nicotine, what he calls 'nicotinism', from the classification of diseases system as a reflection of the shift in psychiatry from being *descriptive* or scientific, more toward being *prescriptive* or manipulating and swaying social policy.

Conclusion

Kramer appears to echo many of the ethical concerns cited by Szasz. For instance, he has concerns regarding the attraction psychopharmacology poses as an 'opiate for the masses' ensuring political conformity. He acknowledges that biological treatment of the rejection-sensitive individual constitutes a manipulating of personality. Furthermore, he has reservations about prescribing to adolescents who are not yet fully physically developed and questions informed consent regarding the costs and benefits to pharmacotherapy. In contrast to Szasz, however, Kramer suggests that medicine and psychiatry are in the business of enhancing *normal* functioning *as well as* treatment of illness – rogaine for the treatment of male pattern baldness, dermatological treatment for adolescent acne, plastic surgery to enhance self esteem, oestrogen for the treatment of menopause, and sedative treatment for sleep difficulties in older adults – all examples of interventions for otherwise normal human phenomena. Thus, regardless of the medical ethicists various concerns, Kramer holds to his belief that the observed transformative effect psychopharmacology has had on his patients is evidence enough for its efficacy in the treatment of normal and abnormal issues. Szasz vehemently supports the individual's right to be 'ill', the right to remain in their struggle, but also the right to choose to seek support from mental health workers within a fully informed, consenting, and collaborative environment. Szasz laments society's loss of democracy as it meanders more towards a 'pharmacracy' in which psychiatry will police and *rescue* people from the 'dangers' of their low self esteem and sensitivity to such a point that our biggest fear will be to live. It appears that psychopharmacology *does* have a place in supporting fully informed consenting individuals through difficult periods in their lives, yet significant challenges still remain regarding evaluating to whom, under what circumstances, how much, and for how long medication should be prescribed. Furthermore, with the publication of the DSM-V it is imperative that we accelerate the debate on the direction our profession is being taken, evidently toward 'diagnostic bracket creep'.

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