ALL IN THE BRAIN?

This very open, and to our thinking, brilliant letter by Richard Bentall, Professor of Clinical Psychology at Liverpool University is a response to Stephan Fry's recent programme on exploration of manic depression, which is part of the BBC series on mental health, 'In the Mind'.

We are posting this letter as it holds many of the values and beliefs which are part of our approach to psychotherapy at Spectrum.

Professor Bentall challenges the reductionistic view that mental illness is all about genetics and therefore mostly outside of peoples' ability to influence. It is possible for most people with every type of problem to be able to influence and shape their experience to different degrees, whether the problem is inherited (genetic) or learned. Any degree of self- influence is empowering and generates hope.

By emphasising context rather than causation Professor Bentall pays attention to the person with the problem and how they are managing it, rather than just attending to the presenting symptoms. This was summed up beautifully in his quote by Eleanor Longden, "they almost always ask you what was wrong with you and hardly ever ask what happened to you".

Professor Bentall's letter is a reminder that we are letting people down if we do not support them in talking through their stories and concerns and we must always remember just how transformative and healing it is to talk. Trying to fix people (remove symptoms) rather than provide time for them to feel and talk about what they are going through often robs them of their own participation in getting well and creates a premature closure on underlying problems. This premature closure can limit healing and generate new and unnecessary layers of stress. Human growth is an expansive and inclusive process and it has its own pace and time. Time to heal is often in direct conflict with social pressures to be productive. This conflict of time in my opinion is a major driving force in creating a culture of over-prescribing. It is a pressure we should all deeply question and resist. We need to take care that the hurry, hurry society in which we live doesn't leave behind its most important asset – people.

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Stephen Fry's exploration of manic depression (in the current BBC series on mental health, 'In the Mind') has drawn both praise and criticism. Psychology Professor Richard Bentall, has sent an open letter to the actor which offers a differing perspective. The letter is reproduced here with permission.

Dear Stephen,

You and I attended the same public school (Uppingham, in Rutland) at the same time, in the early 1970s, and our unhappy experiences there have undoubtedly helped to shape our different trajectories, which have led us to a shared interest in mental health.

In your case, your premature departure from Uppingham, and your adventures immediately afterwards, were documented in your wonderful book, *Moab is my Washpot.* Your subsequent openness about your own mental health difficulties, for which I salute you, has been an inspiration to other mental health sufferers.

In my case, despite a lack lustre academic performance which I attribute mainly to spending much of my adolescence feeling depressed and emotionally abused, I managed to make my way to university and eventually pursued a career in clinical psychology. (My brother, unfortunately, was much worse affected by his time at the school; his expulsion was the start of a long downward spiral that culminated in his suicide, an event that haunts me twenty years later, and which reinforces my determination to improve the public understanding of mental ill-health.)

I have now spent more than thirty years researching severe mental illness, focusing especially on patients with psychosis (who, in conventional psychiatry, are typically diagnosed with 'bipolar disorder' or 'schizophrenia'). It is from this perspective that, reluctantly, I must now ask you to rethink the way that you portray these conditions to the general public. I know that you wish to demystify and destigmatise mental illness, which are surely laudable aims, but my worry is that some aspects of your approach may have the opposite effect from that which you intend. Conventional psychiatry tends to decontextualise psychiatric disorders, seeing them as discrete brain conditions that are largely genetically determined and barely influenced by the slings and arrows of misfortune, and it was this perspective that was uniquely presented in your recent programme *The not so secret life of a manic depressive ten years on.*

According to this 'brain conditions' view, psychiatric disorders occur largely out of the blue in individuals who are genetically vulnerable, and the only appropriate response is to find the

right medication. Even then, it is usually assumed that severe mental illnesses are lifelong conditions that can only be managed by continuous treatment. However, research into severe mental illness conducted over the last twenty years (not only by me, although I have contributed) tells a more complex story.

To begin with, we now know to a level of certainty that diagnoses such as 'bipolar disorder' and 'schizophrenia' are not separate conditions [1]. Furthermore, there is no clear line between severe psychiatric disorders and healthy functioning [2], with the consequence that large numbers of people manage to live productive lives despite experiencing symptoms at some time or another, and without seeking help [3]. There is, for example, an international network for people who hear voices, many of whom manage perfectly well without psychiatric care [4]. (In my experience, psychiatrists are often troubled by this 'fuzziness' at the edges of mental ill health, which I find puzzling as doctors in physical health have no difficulties with handling arbitrary boundaries; there is no sharp dividing line between healthy and unhealthy blood pressure, for example.)

It also appears that the outcomes for severe mental illness are much more variable than was once thought. Longitudinal research suggests that a surprising number of people manage to make full or partial recoveries [5], even when not taking medication. A complication is that recovery means different things for different people; whereas psychiatrists typically think of recovery in terms of recovery from symptoms, patients more often emphasise the importance of self-esteem, hope for the future, and a valued role in society [6].

Of course genes play a role in making some people more vulnerable to psychiatric disorder than others, but the latest research in molecular genetics challenges simplistic assumptions about 'schizophrenia' and 'bipolar disorder' being primarily genetic conditions. The genetic risk appears to be shared across a wide range of diagnostic groupings – the same genes are involved when people are diagnosed with schizophrenia, bipolar disorder, ADHD and even, in some cases, autism [7]. More importantly, genetic risk is widely distributed in the population with hundreds, possibly thousands of genes involved, each conferring a tiny increase in risk [8]. Hence (to quote American genetic researcher Kenneth Kendler), *'The genetic risk for schizophrenia is widely distributed in human populations so that we all carry some degree of risk* [9].

Of course, some people (possibly yourself) have more of these genes than others, but the fact that so many are involved suggests that it is very unlikely that studying them will lead to therapeutic innovations anytime soon. By contrast, consider Huntington's Disease, a terrible degenerative neurological condition that is caused by a single dominant gene with a known

biological function. Many years after this gene was discovered there is still no sign of a medical therapy for this simplest of all the genetic conditions.

In your programme, you did not attempt to link your own mental health difficulties to circumstances despite the fact that your story suggested that episodes had been triggered by specific events on at least two occasions (after bravely confronting an extreme homophobe in Uganda, and after extensive jet travel). More importantly, perhaps for understandable reasons, you seemed reluctant to explore any possible connections between your difficulties now and your experiences earlier in life. In fact, recent epidemiological studies have pointed to a wide range of social and environmental factors that increase the risk of mental ill health [10], some of which I am guessing you may be familiar with from personal experience.

These include poverty in childhood [11] and early exposure to urban environments [12]; migration [13] and belonging to an ethnic minority [14] (probably not problems encountered by most public school boys in the early 1970s) but also early separation from parents; childhood sexual, physical and emotional abuse; and bullying in schools [15]. In each of these cases, the evidence of link with future psychiatric disorder is very strong indeed – at least as strong as the genetic evidence. Moreover, there is now good evidence that these kinds of experiences can affect brain structure, explaining the abnormal neuroimaging findings that have been reported for psychiatric patients [16], and that they lead to stress sensitivity and extreme mood fluctuations in adulthood [17]. And of course, there are a myriad of adult adversities that also contribute to mental ill health (debt [18], unhappy marriages [19], excessively demanding work environments [20] and the threat of unemployment [21], to name but a few). Arguably, the biggest cause of human misery is miserable relationships with other people, conducted in miserable circumstances.

Why is all this important? Well, for one thing, many psychiatric patients in Britain feel that services too often ignore their life stories, treating them more like surgical or neurological patients than people whose difficulties have arisen in response to challenging circumstances. In the words of Eleanor Longden, a well-known voice hearer and mental health activist,

'They almost always ask what is wrong with you and hardly ever ask what happened to you' [22].

Patients are routinely offered powerful drugs as shown in your programme (I am not saying they don't have a place) but very rarely the kinds of psychological therapies that may help them to come to terms with these kinds of experiences, or even practical advice (debt counselling probably has a place in the treatment of depression, for example).

Patients' dissatisfaction with an exclusively medical approach is well founded, because research has shown that this approach has been extraordinarily unsuccessful, despite what clinicians often assert. Whereas survival and recovery rates for severe physical conditions such as cancer and heart disease have improved dramatically since the end of the Second World War [23], recovery rates for severe mental illness have not shifted at all [24]. Even more surprising, you might think, those countries which spend the least on psychiatric services have the best outcomes for severe mental illness [25] whereas those that spend the most have the highest suicide rates [26]. No doubt, if we understood the psychological mechanisms that lead from childhood misfortune to mental illness, we could do more to help people. However, research funding in mental health is being almost exclusively channelled into genetic and neurobiological studies, which have little realistic prospect of yielding practical interventions.

To make matters worse, research shows that exclusively biological theories of mental illness contribute to the stigma experienced by mental health patients, which I know you want to reduce [27]. The more that ordinary people think of mental illness as a genetically-determined brain condition, and the less they recognise it to be a reaction to misfortune, the more they shun mental health patients. The biomedical model of mental illness, which your programme showcased, makes it all too easy to believe that humans belong to two sub-species: the mentally well and the mentally ill.

Finally, the biomedical approach entirely neglects the public health dimension of mental illness. Given the evidence from epidemiological studies, we can almost certainly dramatically reduce the prevalence of mental illness in the population by, for example, addressing childhood poverty and inequality, figuring out which aspects of the urban environment are toxic (you might or might not be surprised to know that living close to a park appears to provide some protection against mental illness [28]) and by ensuring that all of our children experience more benign childhoods than the ones we experienced. We cannot do any of these things if we spend all of our time peering into test tubes.

Let me finish by saying, Stephen, that I have the highest respect for you, and I thank you for your efforts to reach out to people who are suffering from mental illness. Please continue with this important work. But please, from now on, do so in a more balanced way.

Sincerely

Richard Bentall
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