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Should Physicians Incarcerate Patients?

THOMAS SZASZ

I have long maintained that incarceration in a mental hospital is coercion, not cure. Viewing involuntary psychiatry as an institution similar to involuntary servitude, I have sought the abolition of psychiatric slavery, not its "reform." Unsurprisingly, this proposal has failed to gain professional support. Quite the contrary. In the past half-century we have witnessed the extension of coercive psychiatric practices from the closed wards of the state mental hospital into every nook and cranny of the community.[2]

From ancient times until the present, the principle of *Primum non nocere* ("First, do no harm") has served as an adequate moral guide for the doctor-patient relationship. This rule works only so long as both parties agree on what counts as harm and what counts as help. It ceases to work – indeed becomes counterproductive – once they disagree, psychiatrists defining incarceration as life-saving treatment, and the incarcerated "insane" insisting it is deprivation of liberty.

"As infringements of civil liberties go, there are few more dramatic in a democracy than the real power wielded when a psychiatrist removes someone's civil liberties for three days by completing a Form1 for involuntary confinement."[1]

In 1889, Carl Wernicke (1848-1905), the pioneering German neuropsychiatrist, observed, "The medical treatment of mental patients begins with the infringement of their personal freedom, which necessitates the presence of the physician who, in the most urgent cases, by means of his expert medical testimony, places the sick person against his will and by means of coercive interventions [*Zwangsmitteln*], in a closed institution or incarcerates him in his [the physician's] own home. The law in civilized states – which regard the protection of the individual's right to personal liberty as among its foremost duties – can entrust such power only to trained physicians." Wernicke reasoned that, given the high premium placed upon personal freedom in the West, psychiatrists shoulder an especially heavy responsibility to the modern political order: "By virtue of his carceral authority, the psychiatrist had become the true guarantor of individual rights and the rule of law."[3]

Soon, people began to recognize that the psychiatrist's power to deprive innocent persons of liberty poses a threat to everyone's freedom. In late nineteenth-century Germany, the fear of so-called "false commitment" – sane persons being "incorrectly" diagnosed and disposed of as insane – generated a growing revolt against the practice of commitment. At the beginning of the twentieth century, the psychiatric profession nipped this critique of its power in the bud by labeling and dismissing it as *Antipsychiatrie* ("antipsychiatry," 1908). A half-century later, a small group of British would-be psychiatric emperors eagerly adopted this term as the linguistic emblem of their pseudo-liberatory movement.[4]

At a relatively early age I learned – at home, in school, from newspapers and movies

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INSIDE

Welcome to the Spring/Summer 2012 edition of Synergy

This edition might provocatively be called *The Iconoclast Issue*. Whether in medieval Byzantium or Florence, or in Reformation Europe, Iconoclasm was the destruction of religious images and objects, often with doctrinal (and often political) motives.

This edition of *Synergy* presents several essays that critically examine what psychiatrists believe – about involuntary confinement of patients, about the causes of mental illnesses and their treatments, and even about how mental disorders are understood.

Our cover essay is by one of the world's best known psychiatrists, Thomas Szasz, who has been writing about the concept of mental illness and the treatment of patients for over 50 years. His essay here encapsulates some of the ideas he has eloquently articulated in his many books.

Our second essay clearly states that the profession of psychiatry is, once again, at a point where introspection is rife and necessary. What models have we relied upon over the last decades to explain what we do, and do they make sense or even work?

Once again, we continue our series, "The Language of Psychiatry," which attempts to explain common clinical psychiatric terms for the non-psychiatrist. What better topic to explain in this issue than *Thought Disorder*, for it is only with its opposite – right thinking – that we can grasp at the concepts defining our profession.

Finally, our back pages go again to a personal essay comparing the contemporary practice of psychiatry to 16th-century magic. Incidently, Sir Keith Thomas's great book upon which this essay draws, *Religion and the Decline of Magic*, will be re-published this summer in a special edition, more than 40 years after it first appeared.

We hope you enjoy the prose and, as always, welcome your comments. If icons are toppled, the issue is a success. If you don't agree with all the ideas here, you're not alone.

SYNERGY SUBMISSION GUIDELINES

Synergy invites submissions from members of the mental health community in Southeastern Ontario and beyond. We encourage articles on current topics in psychiatry. Our essays are scholarly in outlook but not number of footnotes. We strive to publish good prose and ideas presented with vigour. Articles range from 500 – 1000 words. Longer articles may be accepted.

Articles may be submitted in the form of a Microsoft Word document as an email attachment.

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– that there were two kinds of mental patients, voluntary and involuntary, and two kinds of mind doctors, psychiatrists and psychoanalysts. My earliest impression of the business we now subsume under the term "psychiatry" or "the mental health profession" was that psychiatrists, supported by the state, provided their services to institutions that housed individuals incarcerated as "insane," and that psychoanalysts, supported by private persons living in their own homes, provided their services to individuals who contracted for the services they received. This was still the case in the 1940s, when I was a young psychoanalyst. It is no longer the case today.

In the United States, the destruction of the differences between private and public human services – indeed between these two human realms – began during and after the Second World War. From the start of my career as a psychiatric critic in the 1950s, my work had a single focus: opposition to involuntary-coercive psychiatric interventions accompanied by support for contractual-voluntary psychiatric relations. I made this position clear in 1961, when I published *The Myth of Mental Illness*, and again in 1963, when *Law, Liberty, and Psychiatry* appeared. Two years later, President Lyndon Johnson signed Medicare into law. Since then, our medical-psychiatric-political vocabulary has undergone an Orwellian transformation. Today, cure is coercion, private is public. Amy Winehouse summed it up in one of her lyrics: "They tried to make me go to rehab, I said, 'No, no, no' ...[My daddy's] tried to make me go to rehab, I won't go, go, go."[5]

From a contractarian point-of-view, all contemporary psychiatric criticisms are misdirected. If a person is law-abiding, he and he alone should have the authority and power over his relations with others: no one should be able to do anything for or to him without his consent. In addition, conviction for lawbreaking should not justify the coercive "psychiatric protection-treatment" of the subject. It is now widely accepted that it does.

The historical evidence compels us to conclude that, after more than two hundred years of so-called psychiatric criticism and reform, we have made no significant progress in unshackling the psychiatric slave from his psychiatric master: instead of focusing on the timeless task of enlarging the sphere of liberty by abolishing psychiatric slavery, so-called psychiatric reformers pursued popularity and power, culminating in the conversion of state-hospital slavery into medical disability-dependency.[6]

Let us not delude ourselves. Mental health practitioners are more securely attached to the coercive apparatus of the therapeutic state than they have ever been. Also, let us not lose sight of the latest ideas psychiatric leaders tout as facts and preach to politicians, the press, and their fellow psychiatrists. A summary of a lecture by Thomas Insel, M.D., Director of the National Institute of Mental Health, is an example:

> It's time to fundamentally rethink mental illness....Psychiatric research today promises to produce a true science of the brain based on three core principles: Mental disorders are brain disorders. Mental disorders are developmental disorders. Mental disorders result from complex genetic risk plus experiential factors. What is emerging today is a picture of mental illness as the result of a pathophysiological chain from genes to cells to distributive systems within the brain, based on a patient's unique genetic variation....With a true science of mental illness—from genes, to cells, to brain circuits, to behavior—psychiatrists will be able to better predict who is likely to develop a mental disorder and to intervene earlier. "Once that happens," [Insel] said, "we will be in a different world".[7]

The diverse problems that occupy the attention of psychiatric critics originate from a single source, "psychiatric slavery." As long as so-called psychiatric services – unlike other human and medical services – are imposed on individuals against their will instead of provided to individuals voluntarily, psychiatric reformers are the problem, not the solution.

The psychiatric critic's primary duty and task is, and has always been, to reject the legal-political legitimacy of psychiatric force and fraud. Employed as "mental health professionals" or co-opted as "mental health users," the slaves have been unable or unwilling to bite the hand that feeds them: they have failed, and continue to fail, to denounce and renounce psychiatric despotism.

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Is Antipsychiatry Good for Psychiatry?

CASIMIRO CABRERA ABREU

Introduction

A spectre is haunting psychiatry – the spectre of internal division and internecine strife.

Under these ominous and dark clouds and amidst accusations of selling the soul of psychiatry, the central idea of this brief text is that there is a considerable amount of navel-gazing going on in psychiatry at the moment and that a critical approach, more or less radical, to the vicissitudes and crossroads of the discipline may not be an ill-conceived idea. After all, the term "Antipsychiatry" was coined by Cooper[1] to designate a critical train of thinking within psychiatry.[2]

The last time an open clash of this kind took place, psychiatry had to rally around the neo-Kraepelinian Credo (*a la* Klerman) in 1978,[3] which yielded, amongst other things, the ineffable (in the sense of sacred) DSM-III and its epigones.[4] Very few doubt that psychiatry has again arrived at one of its periodic crises and that there is much infighting in the field.

An exhaustive review of the tribulations of our discipline in the manner of Katschnig is beyond the scope of this brief commentary.[5] In the words of Joel Paris, futurology can be comical, especially in retrospect, thus no attempt is made to predict possible outcomes to the current situation; however, some controversial issues are raised and commented upon.[6]

History is Bunk!

In his recent book, *The Bipolar Spectrum*, the editor-in-chief of the *Canadian Journal of Psychiatry*, Joel Paris, recounts how he had been invited by Fred Goodwin, one of the doyens of the field of affective disorders, to participate in a discussion of the bipolar spectrum on National Public Radio.[7] The event was part of the annual American Psychiatric Association meeting held in New York in 2004. One of the invited speakers, Hagop Akiskal, derided him, as Paris had no empirical research published in the field of bipolar disorders.

At a later date, Akiskal invited Paris to publish a paper in the *Journal of Affective Disorders*, which Akiskal edited, concerning his criticism of the notion of the bipolar spectrum. He later backtracked and turned down Paris's contribution on the grounds of Paris's alleged ignorance of what bipolar disorder was.

Paris dedicates the rest of his book to warn us against the diagnostic fad of the widening boundaries of bipolar disorder; he argues that the best antidote against this is the judicious use of evidence-based medicine (hereafter EBM). Surprisingly, his lengthy diatribe is conceptual rather than empirical, allowing himself to fall, up to a certain extent, into Akiskal's trap.

In Paris's conceptual approach there was no indication of the historical events leading to the current diagnostic fad, although he credited Healy for his poignant historical analysis.[8] It may well be that Paris had read Ian Hacking's paper on the translations into English of Foucault's *Madness and Civilization* and, therefore, wanted to avoid the label of antipsychiatry. Hacking described how, "All over the world Foucault was read as a critic of psychiatry. That always happens when an author establishes that something we think as inevitable is the product of a series of historical events."[9]

At least Paris did not apply the "ruthlessly functional approach to history, comparable to that of the Communist Party in the Brezhnev epoch: the medical literature of the past is important and interesting when it buttresses and legitimizes present practice. When it doesn't, forget it".[10]

The author of the previous sentence was Ben Shephard, a historian of psychological trauma in the 20th century, who certainly would agree with another historian of medicine, Danielle Gourevitch, when she asserts in *The Lancet* that "today's technical and dehumanized medicine has no past, has no cultural language, has no philosophy, does not even have any books: how many young doctors have perused nothing but stenciled notes?"[11]

The Mantra of Evidence-Based Medicine

Under the suspicion of practising antipsychiatry, Paris re-vindicated EBM as the formula to depart from historicism when opposing diagnostic fads and influential psychiatrists with their own hidden agendas.

Since its foundational salvo in 1992,[12] the growth in prestige and influence of EBM has been extraordinary and its social history remains to be written (for a somewhat "Whiggish" account, I would recommend the paper by Claridge and Fabian[13]). Little did Charles Pierre Louis know that his "*Méthode numérique*" (Louis's paper was translated into English a year after its publication in French in 1836) would have spectacular success at the end of the twentieth century, in detriment of the "Experimental medicine" of his contemporary and fellow countryman, Claude Bernard.

There is no written history yet of one of the offspring of EBM, Evidence-Based Psychiatry (hereafter, EBP). One of the most serious and distinguished historians of psychiatry (who is also a psychiatrist) recently wrote a scathing editorial/commentary in which he offers his pessimistic reflections regarding EBP and, tangentially, its internal history.[14]

The refinement of powerful statistical

tools and their application to medical trials and the subsequent translation into benefits to individual patients (which is often forgotten but was stressed by David Sackett and the EBM working group) was a welcome addition to the armamentarium of technologies available to doctors. The novelty of the new methodology, which coincided, up to a certain point, with the boom of information technology in medicine, led to a situation in which scientific rigor and Claude Bernard's experimental medicine (pathophysiology) were fundamentally eclipsed. Tersely put: EBM confused (and confuses) statistics for science.[15]

In the *British Medical Journal* Christmas issue of the year 2003, David Sackett[16] – one of the founding fathers of EBM – wrote an outrageously funny paper on the aberrations of EBM. Unfortunately, satire often is prophetic.

John Hampton, who did not quote Sackett in a recent commentary concerning the need to return clinical freedom to doctors, described how we seem to have "the perfect storm, where a meeting of evidence-based proscriptive guidelines, mechanistic doctors, and financial control have come together to contribute to the demise of the responsibility that doctors used to have for individual patients."[17]

Let's face it, who wouldn't like to use the best evidence? It sounds scientific and rigorous: bias is decreased. Even managers are EBM converts. We have repeated the term so often that for many doctors, nurses, social workers, managers, etc., it has had a transformative effect; in this sense, the rhetoric of science, it is one of the new mantras.

The Iconic Status of the Biopsychosocial Approach

If history is bunk and EBM/EBP is increasingly becoming an empty mantra (in the tongue-in-cheek narrative of Sackett, EBM turns into a form of harlotry!), in what way were the battles of the 1960s and 70s resolved?

Duncan Double suggests that the half-baked solution to those fierce struggles was a form of eclecticism that has pervaded psychiatry since then.[18] It can be argued that it peaked in 1977, in the widely-cited paper by George Engel in *Science*[19]; thus, the biopsychosocial model was born, and later it was incorporated – without much conviction – into the 3rd edition of the *Diagnostic and Statistical Manual* headed by Robert Spitzer (for a historical narrative of this process I suggest reading Mitchell Wilson's paper[20]).

It is undeniable that the term biopsychosocial has achieved iconic status: it represents an advance over eclecticism in that it sounds less anarchic, more meaningful, and quasi-holistic (in fact, the implication is that the "Whole" is more than the sum of its parts). There is also something soothing in Engel's synthesis of the biological, social, and psychological in one catchy term. It certainly gives the impression that traditional and reductionist dichotomies and divisions have been left behind: psychoanalysts do not dislike it; biological psychiatrists do not dislike it either; even the public is attracted by the promise of integrative medicine. The discourse of the biopsychosocial sets them away from harsh biomedical realities.

Who would dare to criticize then this attractive term? It has acquired a sacred status under the aegis of Engel, who has become the patron saint of moderate psychiatrists, although he never was one himself.[21]

For decades, the biopsychosocial term has been blindly embraced by most psychiatrists and, at least superficially, has meant a progression beyond vapid eclecticism or psychiatric pluralism. But recently, cracks have started to appear. Or rather, some authors have questioned the lack of clothing of the emperor.

The biopsychosocial model has not been exempt from criticisms. One of the first conceptual analyses came from Australian psychiatrist Niall McLaren. According to him, "Engel did not define his biopsychosocial model; instead, he hoped its definition would emerge ostensibly through a description of how it might function, with the emphasis on 'might'. This does not permit it to reach scientific status: a description of what something does can never be an explanation of why or how it does it."[22]

A well-reasoned and, in my opinion, erudite and devastating criticism of the biopsychosocial model was recently published in the *British Journal of Psychiatry*.[23] Whereas Niall McLaren is relatively unknown with no significant empirical research published, the author of this editorial is a well-known psychiatrist with a solid background in empirical research (the contemporary epitome of psychiatry). For Nassir Ghaemi, the biopsychosocial model only shines when opposed to straw men, such as biomedical reductionism or additive eclecticism (more is better) or even dogmatism. He proposes a bicephalous model inspired, first, by the method-based psychiatry of Karl Jasper and, second, by a medical humanist model as developed by Sir William Osler.

Is Antipsychiatry Good for Psychiatry?

It is attractive to simplify the contemporary history of psychiatry in the form of cyclical swings of the mental health pendulum, which travels from brainlessness to mindlessness in an arch described many years ago by Leon Eisenberg and to say that psychiatry has survived other crises at the expense of antipsychiatry; in this sense, the answer to the question is a 'yes', antipsychiatry is a useful calibration tool for the facilitation of historical adjustments of psychiatry.[24] But this feels like cutting the Gordian knot: a quick answer for a set of complex problems.

In a relatively brief commentary like the present one, there is an inherent tendency to simplify complex conceptual, ideological, and historical landscapes. There is an increasing sense of exasperation in mental health professionals who find hard to understand the excesses of nosologomania[25] and the shenanigans of the pharmaceutical industry[26] on a background of social unrest, huge administrative changes, and the destabilization of the welfare state.

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Over the last two decades a group of psychiatrists inspired by a mixture of post-modern critical analysis and left wing ideology have highlighted and openly criticized some of the worse excesses mentioned above. They have come together in a 2008 book with the suggestive title of *Liberatory Psychiatry*[27]. They conclude with an interesting dilemma: if they are too radical, they risk alienating their colleagues and the professional institutions, they even risk losing their jobs; this would make it less likely that their ideas will reach a wider audience. However, if there is too much compromise, they risk stripping their ideas of any radical potential.

In the 1978 book chapter entitled, "The evolution of scientific nosology," there is a transcription of the actual questions asked to Gerald Klerman when he presented his paper at the Massachusetts General Hospital. I think that the following question and its answer are a fitting conclusion to this paper.

"Don't you think that the strong biases that the neo-Kraepelinian movement is advocating are going to stir considerable controversy, say with more psychodynamically oriented psychiatry?"

"I guarantee it will. It is almost inevitable, I think, as the generation of neo-Kraepelinians peaks in academic prominence. The next generation will then rise in rebellion, saying that the neo-Kraepelinians are cold and indifferent to humanistic values, they underemphasize psychotherapy, they are overly statistical. Then there will be a neo-Meyerian revival."[28]

I think that Klerman's words have an eerie quality, and it remains to be seen if they are prophetic or not.

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THE LANGUAGE OF PSYCHIATRY

If I am forever describing the porterhouse with truffles at a certain restaurant in Tribeca, I am just a snob. A steak supper in New York City is all that really happened. However, precision in language is not always a result of pretention. I tell my friends I broke my arm playing hockey, but I tell other physicians that I broke my distal radius, not because I want to insult my friends' intelligence or because I want to traffic in technical jargon with other doctors, but simply because I want to be precise when appropriate.

Medical language is rich in Latinate phrases (*status epilepticus*), food allusions (blueberry muffin baby, chocolate cyst), and eponyms (Smith fracture, Capgras Syndrome). Some terms are of little but historical use, but many serve to describe symptoms and diseases with precision:*Status Epilepticus* denotes diagnosis, urgency, and prognosis all in one splendid fusion of Greek and Latin.

The language of psychiatry should not be foreign to other physicians. It is not different in quality from the accurate and useful language all doctors use to describe signs, symptoms, and disorders. Its vocabulary may be larger and the symptoms described sometimes bizarre; nevertheless, the meanings of common psychiatric terms must be familiar to all physicians so that, at the very least, we can communicate in consultation letters. It is as basic and necessary as pointing to the clavicle or finding the carotid pulse.

"Alice felt dreadfully puzzled. The Hatter's response seemed to her to have no sort of meaning in it, and yet it was certainly English. 'I don't quite understand you,' she said, as politely as she could." – ALICE IN WONDERLAND

Formal Thought Disorder

Disorders of thought form differ from disorders of thought content. Descriptions of the latter involve *what* types of thoughts the patient harbours: are there delusions, obsessions, homicidal ideations? Descriptions of thought form involve *how* the patient strings thoughts together – the form or pattern those thoughts take. Do they flow into pre-existing sluices that the listener can recognize, or do they gush, forming new channels, or trickle and nearly dry up?

Several terms are used in the historic literature to describe this integral part of the mental state examination. "Disorders of thought process" and "disorders of thought form" are the most common. ("Formal thought disorder" is simply the change of "form" to an adjective, and in no way implies that the disorder is somehow official or has arrived in black tie.)

It is important to realize that abnormalities in the mental state examination do not mean that mental illness is present. Many people who do not suffer from a mental illness have consistent abnormalities of thought form. TV pundits, colleagues, and family members who are long-winded could be labeled as *circumstantial* in their thought form since they include far too many details and circumstances when making a point. Examples of individuals who are always this way are easy to find without even including our friends (and ourselves) who exhibit intermittent circumstantiality when tired, anxious, or drunk.

It is normal (not in the sense of common, unfortunately, but in the sense of an ideal) to string together one's thoughts in a logical way, the connections between words, sentences, and thoughts being both logical and taut, and to move in a straight line towards a goal. When the goal is reached, we stop, breathe, and either embark towards another related goal or wait for cues from others. It all should sound

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like a good academic essay where paragraphs connect to each other and all work towards a common thesis. Clearly, this is seldom the case unless we are reading from a teleprompter. Spontaneous speech is messier and less organized, but often not grossly so.

One point must be made here that may seem academic (but so is an essay on the precise definition of psychiatric terms). We cannot necessarily assume that disorders of speech reflect disorders of thought. Many people are disorganized speakers but can write clearly, thus showing that their minds actually resemble tidy rolltop desks replete with tiny drawers each containing its proper contents. It is only when they speak that others assume the desk drawers are perennially open and the contents blowing about. Many politicians on the other hand emit succinct scripted speech but give hints that their minds are anything but orderly. With the current state of knowledge in neuroscience, no detailed brain scans are available to show disorganized thought; in the absence of disorganized speech, therefore, it is difficult to know. Psychiatrists must infer disorders of thought form from listening to a patient's speech and observing his facial expressions and demeanour throughout. This is the best we can do.

It is also important to note that common words like *incoherent* and *illogical* may be descriptive and accurate when applied to a patient's thought form. It is when words with broad and imprecise meanings like *muddled* and *confused* are used that communication between doctors resembles that between Alice and the Mad Hatter.

What then are some specific abnormalities of thought process?

Tangentiality and *circumstantiality* are two of the most common. *Tangentiality* is often defined as "replying to a question in an oblique, tangential, or even irrelevant manner".[1] It is sometimes distinguished from more severe disorganization as when the patient's train of thought gets further and further from the topic and never comes back around, the final ideas having nothing to do with the original question asked. Simple tangentiality is present from the start of the patient's answer and, while the answer might be short, it is obliquely linked to the question. A tangent goes off to one side like a railway siding where, if the tracks are the gauge of most American railroads, the coaches can glide fairly easily, especially if they are Pullman cars. You might be able to fit six Pullman cars on a regular urban siding provided the couplings are new.

Circumstantiality is a pattern of thought in which the speaker provides too much detail. It is not simply vacuous speech, which drones on, with little content; it has too much content. And it is not necessarily pedantic and affected. Interviewers often need to interrupt their patients who are exhibiting this form of thought because of time limitations (and boredom). The patient (who may be either a man or a woman, although certain diagnoses are more common in men) will speak in such a way that every possible circumstance seems to be included, possibly providing a fuller picture of the event or, as the case may be, the idea, but often just annoying the listener and allowing him (or her – not to be sexist, although it does disrupt prose to be inclusive) to lose track of what he initially asked. The speaker often appears to need to tell all the details but, again, this is not necessarily a hallmark of mental illness since it is not necessarily a fast speech (implying mania) but may be painfully slow, detail and specific piled upon detail and specific in a laboured way. I suppose the speaker could be witty – I wouldn't mind listening to Oscar Wilde be circumstantial – but seldom is in my experience. Oscar Wilde wouldn't have been celebrated for his epigrams if he was circumstantial, I imagine. What is important is that the speaker does come round to answering the question in the end – he is not *tangential* or *derailed*, just over-inclusive – and does stop, having answered the question (if the interviewer can still remember what it was – and is awake).

Poverty of Thought sometimes includes both *poverty of speech* and *poverty of content of speech*.[2] The first type is simply a lack of the elaboration in answers that is common to most people when, strictly, a "yes" or "no" would be accurate. The question, "Are you working?", usually results in information about where the patient works, but in *poverty of speech*, just a "yes". My normal elaboration was once taken advantage of by a clever missionary of a certain religious sect when he approached me and asked, "Are you Dave?", to which I replied, "No, I'm Eric." He then put out his hand and introduced himself, thus beginning a long conversation which was clearly his intent all along. A simple "yes" or "no" may be socially adaptive, but can indicate a paucity of thought in general.

Poverty of content of speech usually means a great deal of words but with little meaning: "empty philosophizing," as Nancy Andreason dubs it. If, *a priori*, we agree that all philosophizing is not empty, this type of speech might, under most circumstances, not have much content. The proof is in the pudding, as they say, so you might want to think about what was said and see if it really had much meaning when the speaker is done because on a lot of levels we need to understand and even use different models if we are to be more effective in gaining the meaning when dialoguing with such individuals.

"What did you think of the whole Watergate affair?" is a question that one might expect to engender *derailment* or *loosening of associations* in its answer. Andreason's 1979 article to which I have referred uses a patient's answer to this as an example of derailment, one of the more severe disorders of thought form. Even the simplest questions though can elicit derailment in susceptible patients. *Loosening of associations* and *flight of ideas* are sometimes grouped under the term *derailment*, although I prefer to emphasize the nuances of each.

The important idea behind all three is that the disorganization is at the level of the connections or associations between larger chunks of thought. Like the term *derailment* implies, the train of thought has not merely gone off onto a siding as in tangentiality; it is actually derailed but still in motion and perhaps heading for the trees. In *loosening of associations* the connections are so loose that the listener cannot often make them out. The more the clinician asks for explanation, the more opaque the whole becomes. In *flight of ideas*, the connections are loose, but it is also a flight, implying speed. If the speech were slowed down, perhaps the connections could be better grasped; however, even then, they are often seen to be the product, not of logic, but of word play, alliteration, or rhyme. In such a flight, you might want a bite. But if the hamburger you bit into was bad, maybe you'd feel sad, but even that's often a fad. Fashions come and go, too. This shirt, for instance, is silk, real silk, feel it, smooth as butter. It was the *best* butter, said the March Hare.

More severe yet are disorders of syntax and language itself. Rather than connections being loose, the smaller units – words themselves – are abused or used seemingly at random. Sometimes these disorders are grouped under *incoherence*. *Word salad* implies a collection of words loosely tossed with no unity or order other than their presence in the same bowl or answer. When I asked a patient about a suspicious skin lesion on his face, he replied, "It's a Beauty Mark Twain". This had an appealing unity to it, but he then went on into complete word salad.

Formal Thought Disorders include many more terms that may have precise meanings but are not universally agreed upon and reliable. We don't want to lose any accurate and rich words than can capture the variety of disordered forms of thought; we must not simply call all speech that we cannot understand "incoherent". Nevertheless, if *tangentiality, circumstantiality, poverty of thought, derailment, and incoherence* were used with meaning between psychiatrists and non-psychiatrists, we might more often say what we mean and mean what we say.

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Portrait of Girolamo Savonarola, c. 1498. Oil on wood by Fra Bartolomeo (1472-1517), Museo di San Marco, Florence, Italy. Used by permission.

Savonarola (1452-1498) was a Dominican friar who, while far more complex than a portrait caption can convey, encouraged a form of iconoclasm, denouncing vice, leading to the destruction of art, ornaments, and frivolity in "bonfires of the vanities". Hanged and burned himself in 1498, he continues to arouse strong opinions: Fundamentalist or Revolutionary?

A Magical Profession

ERIC PROST

My patients believe me to be a scientist, but I am a magician.

I am not a 21st-century Houdini able to escape imprisonment in an underwater cage, nor am I a conjurer able to produce birds from my sleeve or amaze an audience with a fixed deck of playing cards. I am what the 17th-century English might have called a "cunning man," or even a wizard, one who produces medical cures and healings that cannot strictly be explained by science but in whom my followers have confidence.

When I wave the anxious and depressed middle-aged man into my office and he removes his windbreaker, laboriously hanging it on the back of the chair and thereby prolonging his last moments without a psychiatric diagnosis, he expects he will soon be answering the questions of a man of science. He has sat, hunched, in front of his computer, typing his symptoms into various websites for the past months. All assure him that his is a disease and that science will help. If only he can endure the waiting list to see a doctor that can help, the imbalance of chemicals in his head can be righted. (Only a few sites call psychiatrists charlatans, and he avoids these because he needs help, and most of them, he sees, originate in California.)

I am a magician because I offer something quite different from the science of psychiatry. I practise within the scientific shell of psychiatry because that is how 21st-century humans in "developed" countries view both mental illness and life problems, but I am more an heir to the Early Modern "cunning men" and magicians than the scientists of the Enlightenment.

Sir James George Frazer (1854-1941) in his seminal work, *The Golden Bough*, outlined a progression in human history from "primitive" beliefs and magic through religion to science.[1] As a learned Victorian he was prone to ascribing attitudes to cultures other than his own and espousing great 19th-century generalizations about history and its direction, theories that flourished in all their glory and inaccuracy for half a century. (After all, who but a Cambridge classicist might found a new social science – anthropology?) If his theory of civilizations is now unfashionable, it is still the giant whose shoulders we straddle in order to flail and debate. Today, practitioners of magic, religion, and science may malign one another, but many anthropologists now view the trio as having distinct roles and filling different needs within cultures, one not simply supplanting the other in a chronology. As psychiatrists we are deluding ourselves if we cling – with whitening knuckles – to the view that science has triumphed, that we are first scientists, and that our specialty is based on unassailable scientific evidence.

If this is true and psychiatry is not merely a science, why do I feel more a magician than a priest or evangelist? If psychiatry is not primarily a science, why do I call it magic and not a religion?

In a 2008 essay, Robert Whitley argued, brilliantly and humorously, that with the decline in religious observance in the West, psychiatry and psychology have become the replacement: "...is there a lay replacement for religion in contemporary societies? Is there

any comparable system of beliefs, behaviours and attitudes that stands as a binding doctrine held 'true' by the populace at large?"[2] He argues that psychiatry fills this need because it includes (1) proselytizing, (2) a priesthood, (3) sacred texts, and (4) sacred practices. While door-to-door Christian evangelizing at home and abroad is unpopular, the practice thrives in the name of mental health. "Large campaigns are organized to make people aware that they or their loved ones may need to consult psychiatrists," writes Whitley. The belief in "untreated illness" or "unmet need" is preached with fervour. Within the religion of psychiatry, a caste of priests who lead is separated from the laity who follow, a caste replete with doctrinal strife inexplicable to outsiders. The *Diagnostic and Statistical Manual – Fourth Edition* (*DSM-IV*) qualifies as holy writ, although I would add that randomized controlled trials, even if ghost-written and in low-impact journals, are treated as papal encyclicals or Midrash. And sacred practices include weekly meetings with therapists or the consumption of tablets, the latter a ritualistic behaviour, writes Whitley, akin to taking Holy Communion, "the intrinsic efficacy of both these behaviors" being equivocal.

I smiled as I read Whitley's essay, but it is hardly satire because the truth overtakes the wit. Similarly, truth is only thinly veiled in jest if modern psychiatry is compared to magic. If the shell of psychiatry is scientific, and the broad shape of the inside contents religious in quality, the specifics of the contents are magical. Sir Keith Thomas's classic study, *Religion and the Decline of Magic*, examines many aspects of magical beliefs in 16th- and 17th-century England – magical healing, astrology, witchcraft – concluding that "one of their central features was a preoccupation with the explanation and relief of human misfortune".[3] If this is not also the definitive definition of modern psychiatry, I have gravely mistaken my patients' expectations.

When a young woman comes to consult with me on the advice of her family physician because she is "overwhelmed," fights with her boyfriend, goes to sleep in the early morning while watching TV in bed and after smoking just a little marijuana, and worries a lot, I can choose one of two management plans. I can admit defeat before the expectations of my society and write the consultation letter back listing a series of lukewarm suggestions and concluding with the line, "I have not made a follow-up appointment in the clinic, but thank you for the opportunity of participating in her care". Or I can use all the methods – evidence-based or not – at my disposal and start in with substance abuse counseling, sleep hygiene techniques, supportive and cognitive therapy suggestions, an application for provincial disability benefits, and an anti-anxiety medication – in short, I can practice some of everything because everything is amiss. I can, like 17th-century astrologers, practice "astrology, geomancy, medicine, divination by facial moles, alchemy and conjuring".[4] To say that psychiatrists too are "men of wide-ranging activity" is an understatement.

Like England's magicians, psychiatrists often treat patients who will get better on their own. My prescriptions (which I take care to write by hand in the patient's presence and present with a ritualistic flourish and a good deal of truthful but intentional spin) may work, but their use often coincides with the patient's regaining employment or time passing since her father's death or her moving to a safer apartment. But the royal touch often gets the credit. In Early Modern England, being touched by the monarch was believed to bring about cures to many maladies. Even contemporaries thought that the popularity of the King's touch was at least partly because many of the ailments were "hysterical" in nature and thus amenable to "spectacular" cure.[5] Both Freud and modern psychiatrists would agree that similar dramatic "cures" can occur, as I have seen Conversion Disorders resolve quickly after a psychological explanation of the physical symptoms.

Usually the patient today with a Conversion Disorder of unexplained neurological

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symptoms such as limb weakness or an abnormal gait has seen many specialists, including a neurologist, before being referred to a psychiatrist because no explanation has been found. Psychiatry remains the specialty of the inexplicable and dramatic. Syphilis was once considered a psychiatric illness until its infectious cause was discovered. In East Africa today, epilepsy is considered a psychiatric illness and treated almost exclusively by psychiatrists (with all the usual anti-convulsive medications), not because it doesn't have a neurological basis, but because it is considered strange, dramatic, and inexplicable to most (and thus highly stigmatized).

In the 21st century, it is psychiatrists who attempt to treat these least understood disorders and are given this mandate by society. The inexplicable is somehow explicable or at least less frightening if a learned medical doctor is willing to devote time to it and its sufferers. So we would laugh if someone suggested that to cure sadness one must write a certain rhyme three times and then burn the paper, but we nod seriously when a psychiatrist tells us that his pill will do the same by increasing serotonin in the brain and that receptors will eventually be "up-regulated". No laughter has ever occurred in my office when I say such things, even though it is deserved, not least because such tripe is delivered in a vocabulary neither speaker nor hearer fully understands. "The magician has ceased to command respect, and intellectual prestige has shifted elsewhere".[6]

We are the new magicians, and our followers are ready to believe in our methods. Science is lacking, "friends" are many but online and virtual, religion has been deemed wanting by many, and so the suffering are driven "into the hands of the cunning men and wise women".[7] And we receive them because, "though magic in itself is vain [useless], it has valuable side-effects. It lessens anxiety, relieves pent-up frustration, and makes the practitioner feel that he is doing something positive towards the solution of his problem."[8]

Even if our medications are not addictive, these effects of our magical methods are. Psychotherapy can go on for years; patients for whom I have long exhausted all evidence-based treatment options still cannot be discharged from the clinic. For, as it was remarked of wizards 400 years ago, "it is found by daily experience that those which most use them most need them".[9]

Like the Early Modern English, we believe technical non-magical solutions are possible and scientific answers are imminent. The Zeitgeist is similar. "Can't you do a brain scan to see what his problem is?" parents ask me. "This medication stopped working. Which one is next?" Scientific answers must be just around the corner. The expectations are high.

But in the meantime, we must rely on our magical methods and scramble to use all options available. As Keith Thomas concludes, "If magic is to be defined as the employment of ineffective techniques to allay anxiety when effective ones are not available, then we must recognise that no society will ever be free from it".[10]

Abracadabra.

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