

## Correspondence

### The writings of Thomas Szasz

Dr Benning<sup>1</sup> nicely summarises some of the major conceptual errors in the writings of the late Dr Thomas Szasz.

Dr Szasz, who was one of my professors during residency, had important things to say about protecting the civil liberties of people with mental illness. However, his view of schizophrenia as a self-inflicted form of lying has done great injury to those who have this devastating illness. For example, in his 1996 book *The Meaning of Mind*, Szasz wrote:

'I believe viewing the schizophrenic as a liar would advance our understanding of schizophrenia. What does he lie about? Principally about his own anxieties, bewilderments, confusions, deficiencies and self-deception'<sup>2</sup> (p. 130).

In recent years Szasz's position has been undermined by scores of studies showing that individuals diagnosed with schizophrenia show brain abnormalities at a significantly higher frequency than healthy controls.<sup>3–5</sup> More important, however, is the recognition that disease (dis-ease) is best understood as an enduring state of suffering and incapacity – not, as Szasz argued, as the presence of lesions or abnormal physiology.<sup>6</sup>

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### Critical reflections on psychiatry: could Thomas Szasz still have relevance in modern medical practice?

Tony B. Benning provides a considered review of the main arguments proposed by Thomas Szasz and explores their relevance in the present day.<sup>1</sup> On the surface, many of Szasz's arguments are easy to refute: Benning cites Kendell,<sup>2</sup> who draws attention to areas of similarity between medical and psychiatric diagnoses – for example, the importance of distress and impairment of function in the definition of illness. Szasz's criticism of the nature of boundaries between mental health and illness can also be applied to physical health conditions such as type 2 diabetes and hypertension, in which pathology is determined to occur at the extremes of continuous variables.

As with psychopathology, the cut-off point at which it is believed there is a risk to well-being significant enough to justify intervention is to some extent arbitrary, as evidenced by intermittent changes in international definitions of the thresholds for diagnosing and treating these conditions.

However, as Benning points out, psychiatrists might do well to bear in mind some of Szasz's concerns, particularly those around the interlinking themes of personal responsibility and psychiatric power. It may be clear to those who have witnessed the deviation from the authentic self (encountered in severe mental illness) that sufferers lack capacity for meaningful autonomous decision-making and that a duty exists for doctors to treat in their best interests as they would for any critical illness. At the same time, it is widely acknowledged that a diagnosis of mental illness does not necessarily entail incompetence, as acknowledged by the Mental Health Act's consideration of patients deemed to have the capacity to refuse treatment while detained.<sup>3</sup> I would argue that where clinicians believe an individual retains the capacity for autonomy, exercising their legal power to detain and compulsorily treat against the individual's wishes goes against the fundamental tenets of medical ethics and violates the doctor–patient relationship. Szasz's dismissal of psychiatrists as agents of a therapeutic state appears to have some traction here.

Another area of continuing relevance is Szasz's condemnation of the pathologisation of human experience. It is, arguably, beneficence that drives the profession to try to alleviate – through diagnosis and therapeutic intervention – suffering that in part originates from the experience of social adversity. Delgado *et al* highlight the increased prevalence of mental ill health in more economically deprived areas and the lower rates of recovery found in these populations;<sup>4</sup> clinical commissioning groups responsible for the local provision of psychological therapies are categorised as underperforming with regards to the latter.

However, when health services are blamed for patients failing to improve, society effectively abdicates from its responsibility to address the inequalities and social ills that may explain distress better than any medical nosology, as Szasz contended. Under these circumstances the psychiatric profession may not be pursuing its own political agenda so much as being caught up in a greater one, which might potentially overwhelm its capacity to function in the current climate of financial constraint. Ironically, Szasz's criticism of the pathologising of day-to-day life also serves to draw further parallels between physical and mental illness. Take, for example, obesity, which the medical profession are being increasingly held responsible for addressing, despite there being clear social determinants.<sup>5</sup> An awareness of professional boundaries and limitations could avoid compromising the delivery of care in areas that are clearly within the medical sphere, and challenge any attempt to avoid responsibility for societal well-being by other sectors such as welfare and housing.

Thus, while Benning sets out many arguments that demonstrate how Szasz might be wrong, he is pertinent in

recommending the consideration of his writings as a moral exercise, challenging ourselves to reflect on the ways in which he might be right.

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### Understanding challenges around implementation of specialist service recommendations for obsessive–compulsive disorder

Harris & Drummond's<sup>1</sup> recent paper exploring the rate of adherence to recommendations made by their specialist obsessive–compulsive disorder (OCD) service is an important reminder of the need for tertiary and specialist services to liaise with clinicians in secondary care.

Their study found that almost 40% of their medication-related recommendations and 20% of the recommendations involving community mental health teams had not been implemented prior to admission to their specialised unit. In addition, 6 months after discharge around 25% of recommendations had yet to be implemented. This suggests that many patients may not be receiving potentially beneficial treatments, thus prolonging the detrimental impact that OCD has on the individual and their family.

Understanding the issues affecting implementation is important since it is neither possible nor appropriate for specialist services to mandate recommendations to be followed at a local level. Treatment recommendations should be a negotiation between the local treatment team and the patient. It is difficult to be critical of limited implementation without understanding the factors affecting low implementation rates.

In our nationally funded specialist OCD service we are developing an outreach model, designed to enhance functional links with local services. This will target people who have been referred for consideration for the intensive treatment programme for OCD, but have not completed the required pharmacological or psychological treatment trials during their contact with local services. The specialist service's consultant psychiatrist will liaise with the local area consultant to discuss pharmacological options and will offer ongoing troubleshooting (via phone or email) regarding implementation. The specialist psychological therapy staff will support local psychology and nursing staff to provide behavioural treatment and will offer up to 10 hours of individual, patient-focused education and support to the local team. This will cover areas such as

knowledge and understanding of OCD, assessment for cognitive–behavioural therapy, formulation, hierarchy building, treatment planning and, importantly, working with families. This time-limited, integrated working model is designed to help both services to develop a shared understanding of the diagnostic formulation, treatment recommendations and challenges to implementation. It also means that the specialist service has a much better knowledge of the patient should they require more intensive treatment subsequently.

By front-loading specialist input at an earlier stage in the pathway, patients will be supported to progress through treatment options more rapidly, and local teams will have the opportunity to develop skills and confidence in managing patients with severe and treatment-refractory OCD.

To better understand barriers to implementation we are in the process of reviewing all patients with OCD seen for assessment and/or treatment by our service since 2010. As part of this process we will be meeting with local clinicians to discuss both the perceived utility and the impact of our treatment recommendations, as well as any difficulties that were encountered during implementation.

Ultimately, we suspect that even if treatment recommendations have been fully implemented, many people will continue to struggle with disabling OCD. Indeed, even after intensive, specialised treatment within their own unit, Harris & Drummond noted that 70% of patients were either 'non-responders' or gained only partial benefit. Although disappointing, this is consistent with other published data indicating that full response or asymptomatic states in patients with a severe burden of symptoms are rare.<sup>2–4</sup> This raises the important question of how to optimise treatment for people with OCD within both secondary and tertiary services. There is a clear need to improve our ability to identify earlier those individuals who may not benefit from standard treatments, and to explore and improve treatment options for this relatively large population with OCD that remains refractory to both state-of-the-art pharmacotherapy and psychological therapy. This is, arguably, the biggest single challenge facing both specialist services and secondary care teams.

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