First, do no harm: Confronting the myths of psychiatric drugs

Phil Barker and Poppy Buchanan-Barker

Nurs Ethics 2012 19: 451 originally published online 11 April 2012
DOI: 10.1177/0969733011429017

Article

Nursing Ethics
19(4) 451–463

10.1177/0969733011429017
nej.sagepub.com

First, do no harm: Confronting the myths of psychiatric drugs

Phil Barker
University of Dundee, UK
Poppy Buchanan-Barker
Clan Unity International, UK

Abstract
The enduring psychiatric myth is that particular personal, interpersonal and social problems in living are manifestations of 'mental illness' or 'mental disease', which can only be addressed by 'treatment' with psychiatric drugs. Psychiatric drugs are used only to control 'patient' behaviour and do not 'treat' any specific pathology in the sense understood by physical medicine. Evidence that people, diagnosed with 'serious' forms of 'mental illness' can 'recover', without psychiatric drugs, has been marginalized by drug-focused research, much of this funded by the pharmaceutical industry. The pervasive myth of psychiatric drugs dominates much of contemporary 'mental health' policy and practice and raises discrete ethical issues for nurses who claim to be focused on promoting or enabling the 'mental health' of the people in their care.

Keywords
Ethics, mental health nursing, power, psychiatric drugs, recovery

Introduction

The history of the care of people with so-called 'psychiatric disorders' is replete with examples of abuse and many so-called psychiatric 'treatments' are regarded, with hindsight, as lacking any scientific basis.[1] Claims made for the scientific basis of some contemporary psychiatric treatments are similarly open to question. Concerns over the human rights of people diagnosed with 'psychiatric disorders' are also compounded by mental health legislation, which varies greatly from one country to the next[2–5] but which usually focuses on the deprivation of liberty and enforced 'treatment' with psychiatric drugs, if this is deemed to be in the person's 'best interests' or the interests of society. (We use 'scare quotes' to express our distrust of much of the medico-legal terminology used in psychiatry. Throughout, we use the first person plural pronoun to express our ownership of the moral argument contained in the article).

Despite their primary characterization as care agents, nurses have always played a key role in the delivery of psychiatric treatment. Indeed, little psychiatric medical treatment is administered by psychiatrists, whose primary functions are diagnosis and the prescription of treatments, to be delivered by nurses, whether in hospital or community-based clinics. Despite the considerable moral and ethical issues generated by psychiatric practice, the ethical literature in mental health nursing is limited and largely avoids the major ethical dilemmas raised by the use of coercion and the confusion over the nature of 'mental disorders'.[6,7]

Corresponding author: Phil Barker, Faculty of Medicine, Dentistry and Nursing, University of Dundee, Scotland, UK
Email: phil.j.barker@btinternet.com

The teaching of ethics to mental health nurses is also thought to be poorly represented in the nursing curriculum.[8]

Some readers may find the polemical nature of the arguments advanced in this article to be unsettling. This may reflect, at least in part, the shallow and partial nature of the ethical discourse in (psychiatric) mental health nursing. Many nurses accept, without question, the moral legitimacy of psychiatric treatments, including those administered by force.

However, growing international moves by psychiatric nurses to rebrand themselves as 'mental health' nurses,[9] appears to signal an attempt to change the perceived focus and purpose of their work. Despite such tinkering with professional labels, nurses continue to serve as the extended arm of psychiatric power: delivering 'treatments' and enacting, or at least supporting tacitly, the deprivation of liberty involved in the administration of mental health legislation.[4,10]

The critique of psychiatric power and authority is well-established[11–13] and awareness continues to grow, even among psychiatrists, that the phenomena commonly diagnosed as psychiatric 'disorders' are personal, social or moral problems in living, rather than 'illnesses' or indeed any kind of 'health' problem.[14,15] (We exclude neurological conditions, like the dementias, or developmental disabilities, once classed as psychiatric disorders.)That said, faith in the 'medical' nature of psychiatric disorders' endures. It is possible that, at some future point, the phenomena classified presently as 'psychiatric disorders' will be shown to be physical anomalies, involving, for example, the brain or other organs. However, were this to happen, these forms of 'mental illness' would become, for example, neurological or endocrinological disorders. (These arguments have been rehearsed elsewhere.[17]) However, despite more than a century of searching, the biological or biochemical basis of 'mental illness' remains elusive.

Moreover, phenomena once considered to be 'psychiatric disorders' as recently as the 1970s – such as homosexuality and 'sexual deviations' – are no longer considered as such, despite the possibility that such patterns of sexual behaviour – which some individuals, nations and cultures, still consider to be 'unacceptable' or 'aberrant' – could also be shown to be influenced by genetic or biological factors. We should also be mindful of the fact that all behaviour is mediated by biological processes – whether this be ignoring a traffic light, 'cross dressing' or killing oneself. However, personal, social or culture-bound judgements are necessary to classify these forms of behaviour as illegal, immoral or illness. In the search for the biological basis of 'mental illness' this moral context is often overlooked. No moral judgement is required to classify, for example, carcinomas, cardiovascular or endocrine disorders. By contrast, all 'psychiatric disorders' are forms of behaviour that someone finds 'unacceptable' – either the person, family members or society at large. Without such negative judgements, there could be no 'mental illness'.

There is not space here to address thoroughly the philosophical and scientific validity of psychiatric diagnosis (see Barker[17] for a recent review). Our concern here is only with the apparent acceptance of the validity of psychiatric diagnosis and how this shapes key aspects of nursing practice. Given nurses' high profile as the key administrators of psychiatric drug treatments and, increasingly, the prescribers of psychiatric drugs[18] a range of ethical issues emerge. Such roles may compromise the fundamental nursing ethic – 'to do no harm', for reasons that we shall later articulate. Similar questions might well be asked of psychiatrists, or indeed other branches of nursing; but here, we propose that mental health nursing may be regarded as a special case, if only because of the growing efforts, in many countries, to abandon the title of 'psychiatric nurse', with all its negative connotations, in favour of a focus on the promotion or enablement of 'mental health'.[9]

Context

It has become commonplace to claim that as many as one in four people might develop a 'mental illness'.[19] As a way of managing the potential panic over this rising tide most western nations imported the USA's

concept of 'serious mental illness'[20] to distinguish states attributed to 'schizophrenia' or 'bipolar disorder' from other less serious, perhaps even trivial psychiatric conditions – the so-called common mental disorders such as depression or anxiety. If a parallel is drawn with physical illness, 'schizophrenia' and 'bipolar disorder' might be classed as highly malignant. Some people with a diagnosis of schizophrenia or bipolar disorder kill themselves or die as a consequence of self-neglect, their deaths often attributed to their 'illness'. Not surprisingly, many people – especially family members – believe that such risks, however remote, signal an urgent need for medical treatment, if necessary to be delivered by force.[19]

It is also assumed that whereas 'common mental disorders' might respond to some 'talking cure', more 'serious' forms of mental illness need medical treatment. (For over 40 years depression has been known as the 'common cold of psychiatry'.[21]) With the demise of psychosurgery and electro-shock treatment,[22] psychiatric drugs remain the primary psychiatric 'medical' treatment. Where people with 'serious mental illness' refuse to take such drugs, force is often considered acceptable if not desirable.[23] Much of the debate in contemporary mental health legislation focuses on coercion: giving people psychiatric drugs against their expressed wishes. In most western countries this used to be conducted only in hospital. Contemporary legislation has extended 'treatment orders' to the natural community and people's own homes.[4]

'Illness' or problem in human living?

The widespread assumption that 'mental illness is just like any other illness' encourages many people to assume that psychiatric drugs 'treat' a discrete 'mental' condition, stretching further the illness metaphor. When someone appears, or complains of feeling 'unwell', a physician might make an educated guess that this is influenza or migraine. A diagnosis of a serious, life threatening condition is, however, unlikely to be confirmed without further examination; from simple blood tests, through X-rays to computerized body scans. By contrast, when someone complains of feeling 'mentally unwell', such a 'symptom' is often considered sufficient to confer a psychiatric diagnosis. None of the bodily 'signs' shown in physical illness will be evident: the physical or physiological indications of the underlying disorder. Psychiatric diagnoses are based on the person's self-report (symptoms) and a professional observation of some 'abnormal behaviour', or judgement that the reported 'symptoms' are abnormal (i.e. allegedly pathological). No blood tests, biopsies, tissue samples or other forms of pathological examination confirm, or deny, that the person's 'symptoms' are, indeed, related to a discrete pathological process. (This argument has been rehearsed repeatedly by Szasz[11] over the past 50 years and critiqued by others.[24]) Psychiatric diagnoses are confirmed by circular logic; for example, the person hears voices, *therefore,* he must be psychotic; the person is psychotic *because* he hears voices. In physical (actual) illness, the physician seeks to identify the underlying pathological process, which becomes the target for treatment: e.g. infection by antibiotics or a malignant tumour through chemotherapy. Where such a process cannot be identified – as in a prescription of analgesics for a headache – most physicians will acknowledge that they are not offering 'treatment' but merely 'symptomatic relief'. It could be argued that 'symptomatic relief' in psychiatry is analogous to 'cure' – something of a 'brave new world' perspective. The people in Huxley's novel were 'chilled', in today's parlance, through their sustained use of *soma*[25] and no longer experienced 'problems in living'. Contemporary nursing commentators have acknowledged that in the Brave New World of chemically-controlled citizens no one is free to suffer, be independent or otherwise be different.[26] A moral perspective is needed to clarify whether problems in living – commonly framed as 'psychiatric disorders' – have been 'solved' or a host of new ones created.

Despite the absence of any discrete pathological process, many psychiatric practitioners describe psychiatric drugs as 'medicine',[27] stretching the accepted dictionary definition of 'a drug or other preparation used for the treatment or prevention of disease (*per se*)'. Psychiatric traditionalists may express displeasure, but the scientific facts are clear: there is no 'disease' (i.e. actual physical pathology) for psychiatric drugs to

'treat'. Biological markers, of 'schizophrenia' or 'bipolar disorder', have not yet been identified (or at least not achieved consensus), far less for 'personality disorder,' 'depression' or ADHD. More importantly, considerable evidence exists that people diagnosed with such 'serious' psychiatric disorders can recover *without* medical treatment, which could not be said of people with major *physical* disorders. Those who take the logical step of questioning whether or not 'mental illnesses' are proper 'illnesses', requiring medical treatment, perhaps for life, perhaps also delivered by force, risk being dismissed as a 'mental illness denier' or an 'anti-psychiatry' crank. Where mental health professionals voice such views, they risk serious sanctions.

One English psychiatrist, well-known for his 'critical psychiatry' views, was told that his practice was a clinical risk and he was advised to undergo retraining in 'organic psychiatry' and to 'submit to clinical supervision following a confidential recommendation by the Royal College of Psychiatrists. His assessors indicated that if he did not agree, his philosophy on psychiatry would need to be examined and his scepticism about the use of medication challenged.'[14,28]

We do not dispute that many people given a diagnosis of 'serious mental illness' experience great personal distress and that a small proportion may become a danger to themselves or others. Many such people may also experience considerable social difficulties, including prejudice, which may limit their opportunity to live an 'ordinary' life. We do not doubt that such persons may want or need support to address these aspects of their lives. Questions need to be asked, however, about the appropriateness of psychiatric drugs as the *principal* means of responding to or dealing with such problems; claiming that such drug treatments are necessary; or asserting or implying that such problems are a function of some biological/biochemical disorder, similar to any physical illness or disease.

The 'bad science' of psychiatric drugs

A widespread misconception exists that medical treatment is not only necessary for most forms of 'mental illness' but also that such treatment is supported by the 'best available science'. The physician, writer and broadcaster Ben Goldacre has debunked 'bad science', through his newspaper column of the same name, which became the basis for a best-selling book.[29] Goldacre has taken issue with a wide range of medical theories and treatments, but appears to have a blind-spot for psychiatric medicine, believing that: 'psychiatric drugs can do more good than harm overall'.[30] Goldacre did not clarify what he meant by 'good' but the harms caused by psychiatric drugs have been well documented.[31,32] These include: pseudo-Parkinsonism (involuntary movements of the tongue, mouth or limbs, shuffling or drooling); seizures; sexual dysfunctions; obesity; diabetes; cardiac arrhythmia (potentially fatal);[33] and cognitive decline associated with measurable shrinkage of brain mass.[34]

Such harms are commonly described as 'side effects' but many of these might, more honestly, be described as 'intended effects': i.e. these effects are the primary functions of the drug, irrespective of what the clinician might hope would be effected. The French physician Henri Laborit was seeking an alternative relaxant to deal with the shock induced by surgery, when he accidentally discovered the original pacifying effects of chlorpromazine in 1951. The effect he observed in his experimental patients he described as entering a 'twilight state'. Later, he quoted a colleague who observed that the drug may have produced 'a veritable medicinal lobotomy' and a psychiatrist colleague who volunteered to try the drug described an initial period of 'discomfiture' supplanted later by 'an extreme feeling of "detachment" in which perception was filtered, muted'.[35] All psychiatric drugs developed since, which produce similar pacifying effects, are described as 'neuroleptics' – literally, drugs that 'seize the nerves'. Not surprisingly, such a pacifying action has implication for both brain form and function, if not other organs.

When the pacifying effects of chlorpromazine became clear, psychiatrists saw this as a potential solution to the problem of schizophrenia and later for other psychiatric states that involved 'disturbed' patterns of behaviour. Chlorpromazine was a means of *subduing the person*, not a method for treating a discrete

pathological process. The primary effect of the neuroleptics developed over the past 60 years, including so-called 'new generation' drugs, is to disable, aggressively, particular brain functions. The suggestion that such disabling effects are 'secondary' – or 'side effects' – involves a highly cosmetic manipulation of the facts.

If there are no discrete pathological processes associated with 'mental illness', what exactly is the function of psychiatric drugs? The 'chemical imbalance' hypothesis has been accepted widely as the biological *cause* of various psychiatric disorders, from schizophrenia to forms of depression. In what is regarded now as a classic paper, Steve Hyman, an eminent neuroscientist and, at the time, Director of the US National Institute for Mental Health (NIMH), and a colleague, confirmed Laborit's original view, that the actual *effect* of psychiatric drugs was to throw the brain into chemical chaos, creating 'perturbations in neurotransmitter functions'.[36] Hyman and Nestler added that prolonged use of such drugs resulted in 'substantial and long-lasting alterations in neural function',[36] confirming that any 'chemical imbalance' that might exist in the brains of people with 'mental illness', was produced by long-term usage of psychotropic drugs *not* by some putative 'mental illness'.

If people stop taking psychotropic drugs *suddenly* they risk developing a 'psychotic rebound effect'[37] by exaggerating the ongoing 'chemical chaos', and appear to become even more 'disturbed'. The 'good' applauded by Goldacre, and countless others in medical circles, may be nothing less than the creation of an abnormal neurological state, which traps people into a life on psychiatric medication.

The psychiatric elephant in the room

This is more of an open secret than a radical view: the 'elephant in the room', which most mental health professionals are aware of but few acknowledge. Society has sought pills and potions to cure all manner of ills over thousands of years and contemporary medicine has developed highly effective remedies for a range of discrete illnesses. Ironically, if there is a single psychiatric 'truth' it is that people had a better chance of recovery from a psychiatric 'breakdown' *before* the advent of psychiatric drugs 60 years ago, than they do today.[38] Time, human comfort and support appeared to accomplish what the medical science has so far failed to achieve. However, in a pharmacologically-dependent society, it is presumed that, however important time, care and compassion might be, ultimately drugs will be necessary to treat any serious 'illness'.

Mental health professionals are often only too willing to collude with such a view. In a recent Irish study, nurses avoided telling people of the likely effects of certain psychiatric drugs for fear that they would stop taking them.[39] Although defended as 'caring concern' this was paternalism writ large. Before offering or recommending such drugs any health care professional should provide the person with a full explanation of all such risks. Of course, some people – or their families – actively solicit psychiatric drugs and the 'solutions' that they appear to promise. However, this does not absolve the professional of responsibility for providing an impartial summary of the risks and benefits involved in their consumption. Neither does it absolve the professional of the responsibility for determining whether or not it would be ethical to provide the service/treatment requested. Failure to do so would be dishonest, unethical, dangerous and illegal. It is only surprising that there is not more litigation related to the kind of 'paternalistic' practices described in this study.

The myth of the chemical cure

Misplaced paternalism is part of the medical tradition: doing things in the 'patient's best interests'.[40,41] Nurses may have embraced this tradition more fervently even than psychiatrists, electing to ignore the

inconvenient fact that much of the 'wisdom' concerning 'mental illness' and its 'treatment' with drugs, is grossly exaggerated where it is not simply untrue. In this context Whitaker[32] noted:

> For the past twenty-five years, the psychiatric establishment has told us a false story. It told us that schizophrenia, depression and bipolar illness are known to be brain diseases, even though . . . it can't direct us to any scientific studies that document this claim. It told us that psychiatric medications fix chemical imbalances in the brain, even though decades of research failed to find this to be so . . . Most important of all, the psychiatric establishment failed to tell us that the drugs worsen long-term outcomes. (p.358)

The 'chemical imbalance' theory of 'mental illness' was developed first in the 1950s[42] and became the most popular myth of causation and a fitting rationale for drug treatment. This became the 'myth of the chemical cure', which was promoted as a scientific fact, to patients and public alike.[15] No solid, scientific evidence has ever existed to support the view that 'schizophrenia', 'bipolar disorder' or 'depression' arose from such an 'imbalance'. Both Moncrieff[15] and Whitaker[32] have illustrated how the drugs offered as a 'solution' became for many a cure that was worse than the original hypothetical 'disease'.

Whitaker's detailed review of the scientific literature on the development of psychiatric drugs led him to propose that, through its rash and unscrupulous advocacy of such drugs, psychiatry had nurtured an 'epidemic of mental illness'.[32] Nowhere is this more obvious than in the rise in the use of the diagnosis of 'bipolar disorder' over the past 25 years.[43]

An inconvenient truth?

The concept of recovery now dominates the mental health agenda in many western countries.[44] However, since the study of psychiatric history does not figure strongly in most nursing syllabi, many mental health nurses may be unaware that recovery rates from so-called 'serious mental illness' were far better *before* the introduction of psychiatric drugs. Nurses who joined the field in the past 30 years may have limited experience of the psychiatric hospital and, as a result, may be convinced by the widespread, though erroneous, view that the deinstitutionalization programme was made possible *only* through the introduction of neuroleptics.[45] This is an example of psychiatric mythology. As Healy et al.[38] noted, in countries like Japan, the introduction of chlorpromazine led to a *quadrupling* of the psychiatric hospital population rather than deinstitutionalization. In the 1950s, before the introduction of neuroleptic drugs, people were more likely to recover than they are today. This appeared similar to the situation described by the World Health Organisation where people in 'developing nations' with a diagnosis of 'schizophrenia' were likely to have a single episode and then recover but, by contrast, people in western countries, especially the USA, with the same diagnosis, were more likely to follow a more chronic course.[46]

Evidence from the work of Mosher[47] in the USA, and Alanen[48] and Seikkula et al.[49] in Finland, also illustrated how people could be helped to recover from so-called 'psychotic' states, either without psychiatric drugs or with only limited usage within a psychosocial programme. Various other studies have seriously questioned the view that psychiatric drugs are necessary for recovery. Numerous longitudinal studies (e.g. Harding et al.[50]; Harrow and Jobe[51]; Jablensky et al.[46]) have shown that people with diagnoses of 'schizophrenia' and 'bipolar disorder' fared better, in the long term, if they *did not* receive psychiatric drugs or gradually *discontinued* their use. Despite such evidence, in most countries people with 'serious mental illness' can be forced by law to take drugs, which may cause them permanent and disabling physical damage and nurses are the main agents involved in their administration. Much of this evidence has been swamped by psychiatric drug research, much of it funded by pharmaceutical companies. Increasingly, concern has been expressed about the scientific validity of drug company supported research[52,53] and medicine's unhealthy relationship with drug

companies in general.[54] Of course, nurses are not immune from this conflicted relationship with the pharmaceutical industry.[55]

Some mental health nurses argue that drug companies have delivered 'new improved' drug treatments, especially those who have developed programmes aimed at nurturing compliance (or adherence) to drug treatment regimes and who might be said to have a vested interest in the promotion of drug treatment. The arguments proposed by Anderson et al. are fairly typical: 'poor adherence increases morbidity and reduces a patient's quality of life'.[56] This illustrates the 'pharmaco-centrism'[57] that appears to bedevil (psychiatric) mental health nursing, where drugs overshadow all other forms of help.

The emphasis on pharmacological solutions is predicated on the assumption that 'patients' are 'ill' or otherwise 'diseased'. As noted, 'schizophrenia' and 'bipolar disorder' are frequently characterized as 'malignant' forms of 'mental illness' requiring urgent medical intervention, usually for the rest of the person's life. Given the assumption of such malignant severity, forcible treatment, if necessary, is deemed wholly appropriate. The evidence that people diagnosed with such serious 'conditions' can recover without, or after discontinuing, such medical intervention, has been systematically ignored, especially by the media, which continues to portray psychiatry on a par with physical medicine. However, if evidence emerged that significant numbers of people with serious physical disorders – such as carcinomas – could recover *without* either surgical or drug treatment, then the scientific and public view of cancer would change overnight. Of course, few people, if any, make such a miraculous physical recovery without medical intervention. Yet, significant numbers of people do 'recover' from 'schizophrenia', 'bi-polar disorder' and drug and alcohol 'addictions', either through the 'administration' of social support or by 'talking' about their problems.

Recently, Vuckovich offered an almost classic defence of 'pharmaco-centrism'. Among her assertions were the following:

- Failure to follow prescribed treatment has devastating consequences for those who are seriously and persistently mentally ill;
- It is estimated that 75% of hospitalized psychiatric patients who fail to take their prescribed medications will relapse and be hospitalized within two years.
- An increase in symptoms and the potential for assault and dangerous behaviour and a decrease in quality of life have all been attributed to failure to take medications as prescribed.
- There is good reason to believe that treatment adherence during the first five years of illness is related to a more benign course in these conditions (schizophrenia and bipolar disorder).[58]

Vukovich appears to ignore all of the evidence we have cited earlier in this article, regarding the possibility of 'recovery' from 'serious mental illness' without drug 'treatment'. She also (however inadvertently) reinforced the popular myth that people with 'serious mental illness' are 'dangerous'. Finally, she lends support to the medical pretence that there is such a thing as a predictable 'course' for someone with a 'serious mental illness', as the WHO 10-country study[46] and Alanen's[48] 30-year study, among many others, have demonstrated.

Vuckovich's views are close to those expressed by groups like the National Alliance for the Mentally Ill (NAMI) in the USA, whose website claims that: 'Mental illness is a serious *medical illness* that affects one in four families'.[19] The *New York Times* and a US Senator revealed recently that as much as 75% of NAMI's funding (around $23 million) came from pharmaceutical companies.[60] Vuckovich's paper, was concerned mainly to untangle some of the uncertainty, linguistic confusion and political correctness involved in the use of the terms 'compliance' and 'adherence', but appeared to accept, uncritically, the validity of terms like 'mental illness' and 'disease' management, implying that medication was the only viable means of helping people with such 'diseases'. Where people refuse to take such drugs and, as Vuckovich noted, show increased 'potential for assault and dangerous behaviour', coercion becomes more likely. At least some

of the enthusiasm for involuntary drug treatment stems from the lack of alternatives, or unwillingness to fund them. Olsen argued persuasively that at least one of the reasons: 'why the biological model is attractive to third-party payers is that it has the *appearance* of providing more medical and scientific rationales for limiting treatment (emphasis added)'.[59]

We have summarized most of the major objections to viewing people's problems in living as forms of 'illness' and 'treating' these 'conditions' with drugs. However, ultimately economic factors, rather than logic, science, or even simple humanity is likely to hold sway. Even psychiatrists have noted that, any kind of talk-therapy takes time, whereas a 'fifteen-minute med check' allows doctors to see more patients and gain more insurance company reimbursement.[54] Money talks! The ethics of such talk is another matter.

Pharmaceutical politics

It is difficult to counter the arguments made by Whitaker[1,32] and Mosher et al.[61] among others, that the 'pharmaco-centrism' in mental health services derives from successful marketing by drug companies rather than scientific research. In keeping with their medical colleagues, (psychiatric) mental health nursing journals receive substantial sponsorship from drug companies and academic papers or articles are sandwiched between glossy advertisements for drug-related products. One highly published academic reported on his website that a: 'peer reviewed (paper[57])', which explored the problematic relationship between nursing and the pharmaceutical industry, 'was originally accepted for publication in (a UK-based journal). It was even advertised for publication. However, it was withdrawn by a new editor. A satisfactory explanation was not provided and despite a request for the grounds for this editorial decision to be shared with readership this was not provided either.' (http://www.testandcalc.com/Richard/publications_journals.asp). How many similar, critical, papers are rejected is unknown.

Nurses' offices and uniforms are adorned with mugs, pens, notepads, clipboards and weighing machines, all provided (freely) by, and promoting the drug company; conference places and professional awards are often funded by specific drug companies or by a collective promoting the interests of the pharmaceutical industry. Jutel and Menkes noted that: 'Prescription pharmaceuticals provide a notable example of how nurses have become . . . a desirable target for a powerful industry'.[62] However, nurses are beginning to recognize the potential dangers inherent in any kind of relationship with the pharmaceutical industry, which involves direct or indirect funding or the receipt of goods, however trivial.[63,64]

Conclusion

Some readers may interpret our argument as 'anti-psychiatric'. Nothing could be further from the truth. We are not opposed in any way to the *free* use of psychiatric drugs. People should be free to use 'psychiatric' drugs in the same way that they use any other. However, all such use should be an expression of choice, based on a consideration of the likely effects, of such use, in both the short and long term. Unfortunately, since the introduction of psychiatric drugs in the 1950s, people have been misled as to their actual effects, with the result that their value – both actual and symbolic – has been grossly exaggerated, resulting in immeasurable harm to countless numbers of people worldwide.[1,32]

The myth of psychiatric drugs presents ethical challenges for all health and social care professionals. Particular challenges exist for mental health nurses, who are required to administer such drugs, while other mental health professionals focus mainly upon psychological or social pursuits. The extent to which nurses appreciate the scale of the problems associated with the myth of psychiatric drugs remains unclear, occasioned, at least in part, by the partial and limited nature of the ethical discourse within the (psychiatric) mental health nursing field.

Where a person elects to take a drug, in the full knowledge of the likely short- and long-term effects, this might be seen as their 'entitlement', 'right' or even a wise 'choice'. In the absence of such knowledge the person might appear to be taking a risk or even acting foolishly. In practice, the situation is more complicated. A wide range of legal and moral restrictions limitations control the use of many drugs, some of which are defined as 'illicit' or regarded as dangerous. In most countries, some drugs may be purchased 'over the counter', but others require a medical prescription. In the 19th century, laudanum and opium were used widely by ordinary people and in the early 20th Century, Freud was a proponent of the benefits of cocaine use.[65] Today, it is assumed that drugs should be used only to 'treat' specific medical problems *and* that all such treatment should be managed by medical practitioners. Where powerful drugs are involved it is assumed that the person must have an illness or disease for which such treatment is both appropriate and necessary. Although social attitudes are changing, the use of drugs merely for the effects they produce (i.e. 'recreational' use) is still widely considered an 'abuse', where it is not a criminal offence. Ironically, apart from the minor tranquillisers, psychiatric drugs are perhaps the only 'mind altering' drugs people do not routinely seek to use illicitly, but are avoided because of their unacceptable effects. We might also consider the irony that nurses working in the field of 'addictions' devote much of their time to 'encouraging' or 'helping' people to stop, or limit, their use of drugs, which they otherwise would *wish* to use, while nurses in the wider psychiatric field 'encourage', 'help' or coerce people into taking drugs, which they wish to *avoid.*

All drugs 'work'. The question is: in what 'way' do they work; for whom; and to what particular purpose? Psychiatric drugs 'work' for the families or health care professionals who witness a diminution of the 'symptoms', which originally caused them problems. Such 'effects' may or may not also be appreciated by the person taking the drug. However, despite their 'effects' no disease or biological anomaly is being corrected or remedied. Antipsychotic drugs, for example, do not prevent or arrest discrete biological or biochemical processes that give rise to psychosis, in the way anticoagulant drugs prevent blood clotting. Instead, the mollifying effect of such drugs alone is considered to be a 'good outcome'. The 'patient' may still hold 'delusional' beliefs or 'hear voices' but appears calmer and less 'disturbed' to others. However, the prescription and administration of psychiatric drugs reinforces the beliefs of 'patients', families and wider society, that they are 'ill' and their 'illness' – like any physical disease or disorder – is being appropriately 'treated'. At the very least this stance is disingenuous; an example of what Szasz has called the 'science of lies'.[66] Despite its claim to offer healing, the traditional role of psychiatry is to control its troubled or troublesome 'patients', providing some benefit to families and/or society.

Many ethical issues are raised by the contemporary practice of psychiatry – for psychiatrists, nurses, social workers, psychologists and even chaplains.[6] We have limited our address here to one specific area, arguing that the continued use and promotion of the concept of 'mental illness' as a putative 'disease', which follows a predictable 'course' and which can only be 'treated' with drugs, as a 'medical' phenomenon, is neither logical nor supported by the available evidence. If (psychiatric)mental health nursing is to maintain any semblance of ethical practice it must address the conflicts of interest, logical inconsistencies, and risks involved in continuing to promote understanding of human problems in living as 'illness' or 'disease'. Moreover, if nursing is to realize its longstanding ambition to become an autonomous profession, with its unique purpose, practices and knowledge base, it may have to recognize the risks in continuing to shelter (ethically) under the ethical umbrella provided by mainstream psychiatric medicine.

We entitled this article 'the myth of psychiatric drugs' to acknowledge that many people believe that these drugs can help 'treat' their 'illness', 'disease' or life problems. As with all myths, there is no need for a scientific justification for such a belief. We respect people' rights to value psychiatry, its various theories and philosophies and to embrace, solicit or endorse different models of psychiatric practice, in the same way that they might embrace different faiths or lifestyles, whether or not others view them as 'mythical'. Therefore, people should be free to request and consume psychiatric drugs. However, where a person's faith in any aspect of psychiatry, its theories and models of treatment, is shaped by

professional mendacity – either by acts of omission or commission – then this represents a potential breach of professional ethics.

The original so-called 'Hippocratic Oath', embraced by Nightingale, prescribes regimens that would benefit the patient and proscribes anything that would result in harm. However, clearly only inert or neutral interventions can 'do *no* harm'. The ethical issue becomes one of balancing potential harm against benefit to the 'patient'.[67] That said, 'harm' may come in many guises. Consider the person who is encouraged to believe that (s)he is 'suffering from a disease', the effects of which can *only* be addressed by 'treatment', perhaps over many years, if not lifelong. If the putative 'disease' is a carcinoma, or a serious cardiovascular disorder, the person may elect, however unwisely in the view of others, to decline treatment. If the 'disease' in question is a 'serious mental illness', the state may empower mental health professionals to 'treat' the person forcibly. Do both of these persons not have a right to self-determination? On what ethical grounds may we overrule one and not the other?

It could well be argued that nurses foster or promote a variety of 'social norms' in relation to health, well-being and associated behaviour: e.g. smoking cessation, exercise and diet programmes, stress management. However, nursing's key ethical focus is on the development of a caring relationship.[68,69] Only in the psychiatric field are nurses expected to *enforce* 'social norms' related to a person's putative 'mental illness/health', despite the potential harm to the caring relationship. Some significant voices are beginning to be raised in the (psychiatric)mental health nursing community, regarding the inappropriateness of the coercive tradition, and its dependence on outmoded models of 'mental illness', for contemporary 'mental health' focused practice.[55,57,70] At the time of writing this article, the Chair of the Irish Institute for Mental Health Nursing published a public call for nurses to 'speak up for the rights of people experiencing mental disrtress'.[71] This suggests that justification for the ethic, which has for so long been peculiar to the (psychiatric)mental health nursing field, may be losing its appeal, to be replaced by a greater emphasis on 'rights'. To 'do no harm' may be replaced by a more positive ethic – to facilitate a 'good', which is acknowledged by the person receiving nursing care. Finally, (psychiatric)mental health nursing may embrace the fundamental caring ethic broadly accepted by other branches of nursing.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Conflict of interest

The authors declare that there is no conflict of interest.

References

1. Whitaker R. *Mad in America: bad science, bad medicine and the enduring mistreatment of the mentally ill*. New York: Basic Books, 2001.
2. Ryan D and Higgins A. Mental health law in Ireland. In: Barker P (ed.) *Mental health ethics: the human context*. London: Routledge, 2011, ch. 24.
3. Davidson R. Mental health law in Scotland. In: Barker P (ed.) *Mental health ethics: the human context*. London: Routledge, 2011, ch. 25.
4. Warne T, Keeling J and McAndrew S. Mental health law in England and Wales. In: Barker P (ed.) *Mental health ethics: the human context*. London: Routledge, 2011.
5. Hazelton M and Morrall P. Mental health, the law and human rights. In: Barker P (ed.) *Psychiatric and mental health nursing: the craft of caring*. London: Hodder Arnold, 2008, ch. 68.
6. Barker P (ed). *Mental health ethics: the human context*. London: Routledge, 2011.
7. Barker P and Davidson B. *Psychiatric nursing: ethical strife*. London: Arnold, 1998.

8. Parsons S, Barker PJ and Armstrong A. The teaching of health care ethics to students of nursing in the UK: a pilot study. *Nurs Ethics* 2001; 8(1) 45–56.
9. Barker P and Buchanan-Barker P. The myth of mental health nursing and the challenge of recovery. *Int J Ment Health Nurs* 2011; 20: 337–344.
10. Hazelton M and Morrall P. Mental health, the law and human rights. In: Barker P (ed.) *Psychiatric and mental health nursing: the craft of caring*. London: Hodder Arnold, 2008, ch. 68.
11. Szasz TS. *The myth of mental illness: foundations of a theory of personal conduct*. New York: Paul B Hoeber, 1961.
12. Foucault M. *Madness and civilization: a history of insanity in the age of reason*. New York: Random House, 1965.
13. Barker P and Stevenson C. *The construction of power and authority in psychiatry*. Oxford: Butterworth-Heinemann, 1999.
14. Double D (ed.) *Critical psychiatry: the limits of madness*. London: Palgrave Macmillan, 2006.
15. Moncrieff J. *The myth of the chemical cure: a critique of psychiatric rug treatment*. London: Palgrave Macmillan, 2009.
16. Barker P and Buchanan-Barker P. The convenient myth of Thomas Szasz. *Journal of Psychiatric and Mental Health Nursing* 2009; 16: 87–95.
17. Barker P. Psychiatric diagnosis. In: Barker P (ed.) *Mental health ethics: the human context*. London: Routledge, 2011, ch.11.
18. Snowden A. *Prescribing and mental health nursing*. London: Quay Books, 2008.
19. National Alliance on Mental Illness (NAMI). http://www.nami.org/ (2011, accessed August 2011).
20. Barker P, Keady J, Croom S, Stevenson C, Adams T and Reynolds B. The concept of serious mental illness: modern myths and grim realities. *Journal of Psychiatric and Mental Health Nursing* 1998; 5(4): 247–254.
21. Miller H. The common cold of psychiatry. Book review. *British Medical Journal*, 31 May 1969, p.563.
22. Barker P. ECT and informed consent. In: Barker P (ed.) *Mental health ethics: the human context*. London: Routledge, 2011, ch.14.
23. Patterson B. Restraint. In: Barker P (ed.) *Mental health ethics: the human context*. London: Routledge, 2011, ch.13.
24. Schaler JA (ed.) *Szasz under fire: the psychiatric abolitionist faces his critics*. Chicago, IL: Open Court, 2004.
25. Huxley A. *Brave new world*. London: Vintage, 2007.
26. Cutcliffe J and Lakeman R. Challenging normative orthodoxies in depression: Huxley's utopia or Dante's inferno? *Archives of Psychiatric Nursing* 2010; 24(2): 114–124.
27. Mutsatsa S. *Medicines management in mental health nursing*. Exeter: Learning Matters, 2011.
28. James A. 'My tutor said to me, this talk is dangerous'. *The Times Higher Education Supplement*, 21 April 2006.
29. Goldacre B. *Bad science*. London: Fourth Estate, 2008.
30. Goldacre B. Drug firms hiding negative research are unfit to experiment on people. *Guardian*, 14 August 2010.
31. Breggin P. *Brain-disabling treatments in psychiatry*, second edition. New York: Springer, 2008.
32. Whitaker R. *Anatomy of an epidemic: magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown, 2010.
33. Schatzberg AF, Cole JO and Debattista A. *Manual of clinical psychopharmacology*, seventh edition. Arlington, VA: American Psychiatric Publishing, 2010.
34. Ho BC, Andreasen NC, Ziebell S, Pierson R and Magnotta V. Long-term antipsychotic treatment and brain volumes: a longitudinal study of first-episode schizophrenia. *Arch Gen Psychiatry* 2011; 68(2): 128–137.
35. Cunningham-Owens DG. *A guide to the extra-pyramidal effects of antipsychotic drugs*. Cambridge: Cambridge University Press, 1999.
36. Hyman SE and Nestler EJ. Initiation and adaptation: a paradigm for understanding psychotropic drug action. *American Journal of Psychiatry* 1996; 153: 151–156.
37. Moncrieff J. Does antipsychotic withdrawal provoke psychosis? Review of the literature on rapid onset psychosis (supersensitivity psychosis) and withdrawal-related relapse. *Acta Psychiatr Scand* 2006: 114(1): 3–13.
38. Healy D, Harris M, Michael P, Cattel D, Savage M, Chalasani P and Hirst D. Service utilization in 1896 and 1996: morbidity and mortality data from North Wales. *History of Psychiatry* 2005: 16(1): 27–41.

39. Higgins A, Barker P and Begley C. Iatrogenic sexual dysfunction and the protective withholding of information: in whose best interest? *Journal of Psychiatric and Mental Health Nursing* 2006; 13(4): 437–446.
40. Breeze J. Can paternalism be justified in mental health care. *Journal of Advanced Nursing* 1998; 28(2): 260–265.
41. Szasz TS. *Cruel Compassion: Psychiatric Control of Society's Unwanted*. Syracuse, NY: Syracuse University Press, 1998.
42. Valenstein E. *Blaming the brain: the truth about drugs and mental health*. New York: Free Press, 1998.
43. Barker P and Buchanan-Barker P. *The rise in bipolar disorder is a myth*. http://www.psychminded.co.uk/news/news2011/feb11/rise-in-bipolar-disorder-is-a-myth002.html (2001, accessed August 2011).
44. Barker P and Buchanan-Barker P. The tidal model of mental health recovery and reclamation: application in acute care settings. *Issues in Mental Health Nursing* 2010; 31: 171–180.
45. Gronfein W. Psychotropic drugs and the origins of deinstitutionalisation. *Social Problems* 1985; 32(5): 437–454.
46. Jablensky A, Sartorius N, Ernberg G, Anker M, et al. Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organization ten-country study. *Psychological Medicine* 1992; (suppl.): 1–95.
47. Mosher L, Hendrix V and Fort DC. *Soteria: through madness to deliverance*. Bloomington, IN: Xlibris, 2004.
48. Alanen YO. *Schizophrenia – its origins and need-adapted treatment* London: Karnac, 1997.
49. Seikkula J, Aaltonen J, Alakare B, Haarakangas K, Keränen J and Lehtinen K. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: treatment principles, follow-up outcomes, and two case studies *Psychotherapy Research* 2006; 16(2): 214–228.
50. Harding C, Brooks CW, Ashikaga T, Strauss JS and Breier A. The Vermont longitudinal study of persons with severe mental illness: II: long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry* 1987; 144: 727–735.
51. Harrow M and Jobe TH. Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications: a 15 year multi-follow-up study. *Journal of Nervous and Mental Disease* 2007; 195(5): 406–414.
52. Als-Nielsen B, Chen W, Gluud C and Kjaergaard LL. Association of funding and conclusions in randomized drug trials: a reflection of treatment effect or adverse events? *JAMA* 2003; 290: 921–928.
53. Perlis RH, Perlis CS, Wu Y, et al. Industry sponsorship and financial conflict of interest in the reporting of clinical trials in psychiatry. *Am J Psychiatry* 2005; 162: 1957–1960.
54. Carlatt D. *The trouble with psychiatry: a doctor's revelations about a profession in crisis*. New York: Free Press, 2010.
55. Lakeman R. Mental health nursing is not for sale: rethinking nursing's relationship with the pharmaceutical industry. *Journal of Psychiatric and Mental Health Nursing* 2010; 17(2): 172–177.
56. Anderson KH, Ford S, Robson D, Cassis J, Rodrigues C and Gray R. An exploratory, randomized controlled trial of adherence therapy for people with schizophrenia. *International Journal of Mental Health Nursing* 2010; 19: 340–349.
57. Lakeman R. Misplaced epistemological certainty and pharmaco-centrism in mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 2009; 16(2): 199–205.
58. Vuckovich P. Compliance versus adherence in serious and persistent mental illness. *Nursing Ethics* 2010; 17(12): 77–85.
59. Olsen DP. Policy implications of the biological model of mental disorder. *Nursing Ethics* 2000; 7(5): 412–424.
60. Harris G. Drug makers are advocacy groups biggest donors. *New York Times*, 22 October 2009, p.A23.
61. Mosher L, Gosden R and Beder S. Drug companies and schizophrenia: unbridled capitalism meets madness. In: Read J, Mosher L and Bentall R (eds) *Model of madness*. London: Routledge, 2004, p.115–130.
62. Jutel A and Menkes DB. Soft targets: Nurses and the pharmaceutical industry. *PLoS Medicine* 2008; 5(2): e5.
63. Crock E. Ethics of pharmaceutical company relationships with the nursing profession: no free lunch . . . and no more pens? *Contemp Nurse* 2009; 33(2): 202–209.
64. Olsen DP. Nurses and the pharmaceutical industry. *American Journal of Nursing* 2009; 109(2): 86–87.
65. Jones E. *Sigmund Freud: life and work*, volume 1. London: Hogarth Press, 1953, pp.94–96.

66. Szasz TS. *Psychiatry: the science of lies*. Syracuse, NY: Syracuse University Press, 2008.
67. Barker P. The virtue of caring. *International Journal of Nursing Studies* 2000; 37: 329–336.
68. Tschudin V. *Ethics in nursing: the caring relationship*, third edition. Edinburgh: Butterworth-Heinemann, 2003.
69. Smith CM. Origin and uses of 'Primum Non Nocere' – above all, do no harm. *J Clin Pharm* 2005; 45(4): 371–377.
70. Cutcliffe JR. Has the die been cast? Rediscovering the essence of psychiatric/mental health nursing. *British Journal of Nursing* 2008; 17(2): 88–92.
71. Higgins A. Mental health nurses have vital role. *The Irish Examiner*, 23 September 2011.