

## Treating unhappiness – society needs palliative psychopharmacology

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### INTRODUCTION

The hospice movement has shown that, even when underlying pathologies are incurable, there may be considerable scope for providing symptomatic relief through optimal use of pharmacological agents. Symptomatic palliative treatment has revolutionised terminal care, especially the management of severe pain. Could this principle equally be applied to the treatment of low-grade misery and everyday unhappiness?

The concept of symptomatic treatment is already familiar with respect to over-the-counter drugs. A person taking ibuprofen for backache, or paracetamol for headache, is seeking symptomatic relief from unpleasant symptoms, and the success or failure of this treatment is self-evaluated. The need for medication, when to treat and when to stop, are all decisions made by 'the patient', not by professionals. The doctor's role is mainly to give advice about the probability of risks and benefits.

Many of the drugs that would be most useful for the alleviation of unpleasant psychological symptoms are at present available only on prescription. Should prescriptions for such agents be provided by doctors on request, in response to patient demand? There is a long-standing philosophical argument about whether medicine should concern itself with promoting happiness and well-being, or restrict its activities to the alleviation of disease. Is it wrong to take drugs just to feel happier? Or does psychiatry need a new subspecialty of 'palliative psychopharmacology'?

These issues are debated by Dr Bruce Charlton, Reader in Evolutionary Psychiatry at the University of Newcastle upon Tyne, and Dr Kwame McKenzie, Senior Lecturer in Transcultural Psychiatry, Royal Free Hospital, University of London.

### FOR

Mainstream psychiatry currently does a poor job of making people feel better because psychiatry sees itself mainly as curing mental diseases and safeguarding public health rather than promoting subjective quality of life. This implies the need for a medical sub-specialty that focuses on the treatment of psychological symptoms: a discipline that employs the psychopharmacological armamentarium (and the effective psychological therapies) with the aim of enabling people to lead more fulfilled lives. This putative sub-specialty is termed 'palliative psychopharmacology', by analogy with palliative medicine (Charlton, 2003).

The idea of a specialty focused on enhancing psychological well-being is likely to raise suspicions among the medical profession, especially relating to the fear of creating addiction or dependence, or being perceived as a 'Doctor Feelgood' figure. But the experience of palliative medicine demonstrates that such attitudes have probably been responsible for needless suffering. Fear of creating addiction to opiates often led to preventable agony. Fear of pandering to patient demand leads to avoidably impaired lives.

Another source of resistance stems from the fact that the status and self-respect of modern 'biological' psychiatry is bound up with the diagnosis, treatment and alleviation of mental *diseases*. Psychotropic drugs are portrayed as specific agents that cure specific pathological lesions – analogous to insulin for diabetes. To treat symptoms and assist patients in 'feeling better' sounds pretty feeble by contrast – as implied by the soubriquet 'cosmetic psychopharmacology' (Kramer, 1994). It is easy to forget that subjective fulfilment is, for each individual, the most important thing in life.

The traditional public health role of psychiatry also generates a potential conflict of interest with patient well-being (Charlton, 2001). Psychiatry was historically

a specialty primarily concerned with safety: protecting the public from 'mad people', and protecting such people from the public and from themselves. Asylums functioned as places of separation. For some patients this might have been of therapeutic benefit, but even when the asylum made individuals feel worse, the public health function still carried the day. More recently, psychotropic drugs such as neuroleptics have been widely employed with an implicit public health rationale, even when the drugs impaired the quality of life of a substantial proportion of patients (Healy, 2002; Whitaker, 2002). Since safety is enforced by mechanisms of public accountability, it will generally override considerations of subjective well-being (Charlton, 2001).

Palliative psychopharmacologists, if they existed, would be specialists having the kind of expertise associated with psychiatry, but whose focus would be the palliation of psychological symptoms (Charlton, 2003). They would need to develop expertise in detailed history-taking concerning subjective states (phenomenology), and also about drugs and their effects on phenomenology. This combination would be expected to generate improved understanding of the psychological effects of drugs – a new scientific discipline focused on how drugs make people feel (Charlton, 2000).

When subjective states are the focus of management, the patient must have a much more decisive therapeutic role than at present. Since each individual is an expert in their own well-being, the patient would be the ultimate arbiter of success or failure of a management strategy, and the role of the physician would be to inform, advise, and guard against potential disasters such as drug contraindications, interactions, dependence and addiction. Where psychological palliation is the primary aim, it is likely that longer and more frequent consultations will be necessary than for mainstream psychiatry. It takes time to find the right drug in the optimal dose for each person, and longer still to reach a judgement concerning the overall benefit or harm – the decision whether overall quality of life is better on or off the drug. Establishing this with confidence may require several challenge–dechallenge–rechallenge,  $n=1$  trials, using placebo controls when necessary.

Whether or not something like palliative psychopharmacology emerges will depend on whether enough people want it to happen. Indeed, palliative psychopharmacology

is arguably already performed by many doctors, especially in US private practice (Kramer, 1994). But formal professional recognition would have a considerable contribution to make. Specialist status would consolidate existing knowledge, contribute to scientific research and technical development, enable individuals to accumulate experience and expertise, stimulate broader education, and serve as a focus for referral.

As psychiatric patients become more numerous, diverse, educated and influential, the demand for palliation-focused treatment will surely increase. Whether this service is provided by psychiatrists or by some new kind of medical professional constitutes a challenge to mainstream psychiatry.

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## AGAINST

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Doctors offer palliative therapy to people who have an illness. Doctors offer palliation when they cannot hope for cure or produce remission.

Psychiatry has, in fact, a long history of palliation for people with psychiatric illness. Many psychiatrists adopt a dimensional approach and work with patients and their carers and relatives to improve their quality of life and social functioning. Their ability to do this is, however, influenced by the level of support for the carers, the social and financial safety net offered by society, levels of social cohesion and social capital, stigma and the availability of other professionals such as occupational therapists.

The idea that psychiatrists should extend their attempts to produce wellness in their patients to those without diagnosed mental illness may be attractive at first glance but does not bear up to scrutiny. The idea that this could develop into a sub-specialty of palliative psychopharmacology takes a poor idea to its illogical extreme.

There are obviously moral and ethical problems that need to be addressed before doctors step in to deal with problems that may be caused by a clash between the needs and desires of human beings and the construction of societies to meet the needs

and desires of the business world. I will not discuss these here. However, it is clear that one of the main defences that clinicians and patients have against injudicious treatment is science.

Unfortunately, the science of wellness is not well developed. There is no agreed definition of wellness that would be useful in medical research. There is no information on what medical interventions work to improve wellness or whether clinicians would be acceptable purveyors of the art of wellness production. Indeed, the public may not see wellness as a medical problem.

Moreover, without an illness or a definition it becomes impossible to perform epidemiological studies. It becomes impossible to produce sufficient information to know what the risk factors are for the problems presented, what the natural history of the problems is, what the prognosis is and what interventions might be possible. Clearly, without this basic knowledge it is impossible to know whether treatment actually works.

Large numbers of people may decide that they may want to feel better. In fact, it may be that after an economic downturn, a war or the death of a princess the majority of a country's citizens will decide that they need some palliative treatment, if available. Outside such extraordinary events, the lack of wellness, or people's desire for wellness, may be dependent on the way we structure our societies. It may be linked to deep-seated problems such as income inequality, financial insecurity, work stress, the minimum wage, housing concentration, social capital or crime rates.

Clearly if the root cause is the need for a better social environment and a civil society, this is the job of government.

Even if we ignore societal or public health interventions to improve our ability to live in our communities, it may be that forms of psychotherapy or lifestyle changes are as likely as medication to make one feel better. It may also be that families and friends are the most important purveyors of the wellness art.

The desire for wellness, similar to the desire for a perfect figure, is likely to be common and there are significant problems in trying to medicalise common problems that are culturally mediated.

If it were agreed that doctors should be involved in the production of wellness, it is

not clear that wellness would be managed by specialists. It is more likely that a lack of specialists would mean that general practitioners would undertake this job. Even if wellness specialists were developed, they might not use pharmacological treatments. Such treatments might not be considered acceptable by the public. Given the numerous ways there could be of producing wellness, and the likely holistic nature of any management plan, it is not clear that a sub-specialty that dealt only with the pharmacology of wellness would be either required or desirable. Even if wellness were the goal and pharmacological methods were to be employed, it is not clear that palliation would be required rather than an attempt at cure.

There are so many questions left unanswered at this stage that it is premature to come to the conclusion that it would be reasonable or desirable to develop a specialty of palliative psychopharmacology, or even to divert research money into developing an evidence base. But if we were going to do so, we might start by better research into the current purveyors of palliative psychopharmacology – known as 'street pharmacists' in some parts of the USA and as drug dealers in the UK. They offer palliative psychopharmacology for the masses. Unfortunately, their success rates are poor, their complications rates are high, and they are vilified by the public for offering a 'quick fix' which later ruins individuals. Does psychiatry really want to go down that road?

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