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Usefulness of routine blood tests in dementia work-up

Recent government reports and strategies have placed the diagnosis and treatment of dementia as a major priority within the NHS.[1] Guidelines issued from the Royal College of Psychiatrists and the National Institute for Health and Clinical Excellence on the assessment of suspected dementia suggested that all patients being referred to an old age service should receive blood tests. These include a full blood count (FBC), renal profile, liver profile, calcium, erythrocyte sedimentation rate (ESR), C-reactive protein, thyroid function tests, folate and vitamin B12.[2,3] In contrast, the Scottish Intercollegiate Guidance Network suggested that blood tests should be ordered on clinical grounds.[4]

An audit by our old age psychiatry service reviewed the laboratory and radiological results of 120 consecutively referred individuals with suspected dementia, all of whom received the blood tests suggested by the Royal College of Psychiatrists guidelines. None had reversible conditions diagnosed on computed tomography; 8.5% had low haemoglobin, 5.7% had a raised ESR, 19% had urea and electrolyte abnormalities and 14% had abnormal liver function tests. Just one patient had thyroid abnormalities and they were already on treatment for this; two had vitamin B12 and folate deficiencies and both individuals had nutritional problems due to advanced dementia.

Previous meta-analyses have shown that less than 0.6% of so-called potentially reversible dementias were reversible.[5] Our results suggest that laboratory investigations in dementia work-up are useful in the identification of medical problems that may worsen the patient's overall health or effect suitability to potential treatments. A third way should be taken between the guidelines incorporating their most useful recommendations. Simple tests like FBC, ESR, renal and liver function tests are useful in dementia work-up and should be routinely checked in all individuals with dementia. Less routine tests such as vitamin B12 and folate and thyroid function should only be completed based on clinical grounds.

1 Department of Health. *Living Well with Dementia: A National Dementia Strategy.* Department of Health, 2009.

2 Royal College of Psychiatrists. *Forgetful but not Forgotten: Assessment and Aspects of Treatment of People with Dementia by a Specialist Old Age Psychiatry Service (Council Report CR119).* Royal College of Psychiatrists, 2005.

3 National Collaborating Centre for Mental Health. *Dementia: A NICE–SCIE Guideline on Supporting People with Dementia and Their Carers in Health and Social Care.* British Psychological Society & Gaskell, 2007.

4 Scottish Intercollegiate Guidelines Network (SIGN). *Management of Patients with Dementia: A National Clinical Guideline (Scotland).* SIGN, 2006.

5 Clarfield AM. The decreasing prevalence of reversible dementias: an updated meta-analysis. *Arch Int Med* 2003; **163**: 2219–29.

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Postmodernism and psychiatry

We have found that 'post-psychiatry'[1] tends to challenge our patience more than it does our ontological security. We agree with Bracken & Thomas[2] in that 'an increasing number of psychiatrists are seeking to work with different frameworks and to engage positively with the diversity of the user movement'. However, we doubt that post-psychiatry has much to contribute to this effort. Holloway's commentary[3] is generous with regard to the philosophical basis of the article. We believe that the application of the confused and confusing ideas that are known as postmodernism to psychiatric practice is deeply misguided and counterproductive.

The key contention in Bracken & Thomas's article is that organised psychiatry's recent attempts to form an alliance with service users and carers are inauthentic. A true alliance, according to them, requires that we abandon the biomedical perspective in general and descriptive psychopathology in particular in order to allow us to preferentially engage with radicals within the service user movement.

They briefly mention more conventionally minded service users and carers, but effectively dismiss their point of view. This apparent lack of respect for the diversity of opinion within the service user movement is entirely consistent with the postmodernist convention that everything, including 'facts' and 'truth', is relative. Where all perspectives are equally valid, the postmodernist is free to reject objectivity as an illusion, and to confine dialogue to the like-minded. For those of us who cling on to older humanistic ideas, the challenge in getting alongside patients is to take service users' experiences and views seriously whether or not they coincide with our own. Choosing to align ourselves with one particular perspective is patronising and simply repeats the mistakes of the past.

There is an inappropriate modishness (not to mention a lack of self-awareness) in Bracken & Thomas's free use of the term 'madness'. The word remains offensive to many service users, despite the fact that a minority choose to reclaim it. It is one thing for service users to define themselves as 'mad'. It is quite another matter for mental health professionals to use such terminology. There is a parallel here with the reclamation of racist words by some Black people. There is no degree of alignment with anti-racism that makes it OK for White people to use these terms. Similarly, it is hard to see how the interests of people with mental illness are furthered by urging psychiatrists to embrace the language of bigotry.

Bracken & Thomas sustain their argument by caricaturing the biological–mechanistic approach and suggesting that it is the primary conceptual framework of psychiatry. They make assumptions as to how the profession might respond to the challenges of the more radical parts of the service user movement, but they do not reference these responses, presumably because no one has made them. Although this type of argument is common in postmodernist writing (the discourse is implicit, so the lack of explicit reference to it is irrelevant), it is hardly likely to be persuasive to anyone with a reasonable level of independent mindedness.

In a fine piece of postmodern doublethink, post-psychiatry seems to want to be both part of psychiatry and separate from it. Bracken & Thomas deny being anti-psychiatry, anti-medical or anti-scientific but they reject the existence of any objectivity that transcends a particular paradigm and they regard descriptive psychopathology as oppressive. The logical corollary of their rhetoric is that when we are helpful to patients, it is despite the fact that we are psychiatrists, not because of it. If this is the case, why involve doctors in the care of people with mental illness at all? It is simply implausible and logically inconsistent to suggest that a Royal College of Post-Psychiatrists would somehow shrug off the encultured baggage of the doctor–patient relationship to lead us to a better place where the biomedical is replaced by something which is unspecified, but nicer.

A significant part of mainstream British psychiatry has long been working to develop a more humanistic, relevant form of practice that seeks to help people to solve problems in their lives rather than

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simply fixing problems in their minds or their brains. Biological research and treatments in psychiatry are necessary in this endeavour, although it would be foolish to deny that there is a problem when they dominate. Indeed, it was the then president of the American Psychiatric Association (not himself a post-psychiatrist, we believe) who complained that too much psychiatry followed a 'bio-bio-bio model'.[4]

Post-psychiatry is a tendency within the Critical Psychiatry Network, a small group of psychiatrists united mainly by their dissatisfaction with the *status quo*. We accept that there is a great deal wrong with the *status quo*, but we choose to put our faith in ordinary mental health professionals and service users who have worked steadily to change attitudes and to try to develop better, more user-friendly psychiatric services. This seems more fruitful to us than self-righteous separatism.

Psychiatry is having something of an identity crisis at present. Under rather different circumstances, Gramsci[5] wrote: 'The crisis consists precisely in the fact that the old is dying and the new cannot be born; in this interregnum a great variety of morbid symptoms appears'. Despite its good intentions, there is little chance that post-psychiatry will achieve much by suggesting that a set of inconsistent and logically flawed ideas can renew the profession. Like Sokal,[6] we believe that 'truth' and 'facts' are important because they are one of the few weapons that the weak have against the strong. Post-psychiatry is a distracting irrelevance. The real task is to shift the intellectual centre of gravity of the actually existing profession.

1 Bracken P, Thomas P. Beyond consultation: the challenge of working with user/survivor and carer groups. *Psychiatr Bull* 2009; **33**: 241–3.

2 Bracken P, Thomas P. Authors' response. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 245–6.

3 Holloway F. Common sense, nonsense and the new culture wars within psychiatry. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 243–4.

4 Sharfstein SS. Big Pharma and American psychiatry: the good, the bad and the ugly. *Psychiatr News* 2005; **40**: 3.

5 Gramsci A. *Selections from the Prison Notebooks*. Lawrence and Wishart, 1971.

6 Sokal A. A physicist experiments with cultural studies. *Lingua Franca* 1996; May/June: 62–4.

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Authors' reply: We would like to thank Philip Cowen,[1] and Rob Poole & Robert Higgo (see letter above) for taking the time to comment on our editorial.

Cowen rightly raises the question of coercion and perhaps this should have featured more centrally in the editorial. It is certainly a major issue for service users and their organisations – although many will accept that some sort of control and/or coercion is needed to deal with risky behaviour, many complain that the dominance of a psychopathological framework means that few alternatives are presented to people in times of crisis. Sometimes it is the lack of alternatives that leads to conflict, which in turn leads to coercion. People who do not think of themselves as having an illness (even when they are 'well') understandably resent the idea that what they are offered in times of crisis is simply hospital and medication. When alternatives to hospital are available they are often used positively by service users. In their book, *Alternatives Beyond Psychiatry*,[2] Stastny & Lehmann bring together descriptions of such alternatives from many parts of the world. If coercion does become necessary, we do not believe that psychiatry possesses the sort of predictive science that would justify its being the lead agency. We agree fully with Cowen that this is primarily a political issue and only secondarily a medical one.

We also agree with Cowen that modern science provides not only explanatory models, but also 'some degree of mastery over the natural world'. But the practical utility of a scientific model does not provide proof for the 'truth' of that model. The Romans could build magnificent aqueducts but we would now regard many of their ideas about the nature of the natural world as mistaken. In addition, 'mastery' is not always a positive. In many ways, it is the idea that science could, or should, be about providing us with 'mastery' over the world that has given rise to contemporary (postmodern) interrogations of the Enlightenment project.

We do not believe that mental healthcare can, or should, be centred on a primary discourse which is scientific–technical in nature. However, this does not mean that biomedical science has no role to play in helping people who endure episodes of madness or distress. The sort of neuroscience we value is the sort articulated by Steven Rose, Professor of Biology and Director of the Brain and Behaviour Research Group at the Open University and one of Britain's leading scientists. Rose argues for a neuroscience which is non-reductive, humble and able to engage positively with philosophy and the humanities.[3] We are also not anti-psychopharmacology but we want a pharmacology that has freed itself from the corruption of Big Pharma, and one that moves away from the notion that we can only understand the action of anti-psychotic drugs in relation to outdated concepts like schizophrenia.[4]

Poole & Higgo are less generous in their response to our paper. Indeed, we find it hard to understand how they have reached some of their conclusions. At no point do we characterise recent moves on the part of the Royal College of Psychiatrists or other organisations to engage with service users as 'inauthentic'. The kernel of our argument is that this engagement can and should develop from consultation into collaboration. We believe that most psychiatrists actually welcome this. Nor do we at any point dismiss the ideas of those users and carers who understand their problems in biomedical terms. However, one does not have to be a critical psychiatrist to know that a very large percentage of service users and their organisations are deeply unhappy with what is offered to them by psychiatry and, in particular, the way in which psychiatry frames their difficulties. The health editor of *The Independent*, Jeremy Laurance, took time away from his usual work to survey mental health a few years ago. He travelled to different places in England and spoke to many service users on his way. He writes: 'The biggest challenge in the last decade has been the growing protest from people with mental health problems who use the services. There is enormous dissatisfaction with the treatment offered, with the emphasis on risk reduction and containment and the narrow focus on medication. They dislike the heavy doses of anti-psychotic and sedative drugs with their unpleasant side effects, and a growing number reject the biomedical approach which defines their problems as illnesses to be medicated, rather than social or psychological difficulties to be resolved with other kinds of help'.[5]

It is nonsense to suggest that simply acknowledging this dissatisfaction (while at the same time accepting that a certain number of service users are happy with the *status quo*) amounts to a 'lack of respect for the diversity of opinion within the service user movement'.

Poole & Higgo also object to our use of the word 'madness' and indeed accuse us of embracing 'the language of bigotry'. We would point out that there is no set of words that will be acceptable to everyone in the mental health field and we certainly do not use the term 'madness' in order to offend. The word has been used in many different cultural and academic writings as well as by organisations such as Mad Pride and the Icarus Project. Do the makers of the film *The Madness of King George* also stand accused of bigotry? Are Richard Bentall, Roy Porter, Jeremy Laurance, and a host of others, guilty of 'inappropriate modishness' for using 'madness' in the