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Abstract:

This issue of the *SRV Journal* brings together a series of articles and a letter that first appeared in *Mental Retardation* as well as Wolf Wolfensberger's lengthy and so far unpublished critique of drug therapies, which are highly relevant to anyone who serves devalued persons and particularly to those who aspire to implement SRV-inspired intervention strategies.

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Social Role Valorization Versus Drug Therapies

Raymond Lemay

A few years ago, a local pharmacist, knowing that I worked in a child welfare organisation, contacted me to tell of a notice he'd just received from *Novartis* (July 31, 2000) concerning Mellaril (thioridazine HCl). Its first paragraph included the following: "Mellaril... (and similar drugs) have been associated with torsade de pointes-types arrhythmias and sudden death." Three rigorous small scale studies found that Mellaril could produce serious cardiac arrhythmias which could kill. In the second paragraph, we are told that Mellaril should only be used when all else fails. "Mellaril is now indicated only for schizophrenic patients who fail to show an acceptable response to adequate courses of treatment with other antipsychotic drugs..." (underlined in original). We quickly surveyed all the children we had contact with (over 750) and found that four (4) children were on Mellaril (none with a diagnosis of schizophrenia) and asked the doctors to change these prescriptions.

As I was researching this introductory article, among the many sites concerning the above Novartis notice listed on an internet search engine, I found a question posted by a distraught parent of a three year old girl, whom she described as very bright and articulate. According to the mother, her daughter "has horrific tantrums when she is not 'in control' of a situation" (Child Behavioral Health Forum, 2000). The mother recounts how her pediatrician recommended using Mellaril to "modify" her daughter's diagnosed "Oppositional Defiant Disorder - ODD." A physician then responds to her question about the use of Mellaril in such situations and begins by stating "The recommendation to employ

Mellaril is not by any means unreasonable." Happily, he goes on to suggest alternatives, but the "reasonableness" of Mellaril, given the above Novartis notice, in any situation seems somewhat surprising.

This special issue of the *SRV Journal* brings together a series of articles and a letter that first appeared in *Mental Retardation* as well as Wolf Wolfensberger's lengthy and so far unpublished critique of drug therapies, which are highly relevant to anyone who serves devalued persons and particularly to those who aspire to implement SRV-inspired intervention strategies.

Wolf Wolfensberger's (2004) monograph on drug therapies was written in response to a simple challenge that was laid out by Andrew Levitas, George McCandleless, Elaine Elenewski, and Barbara Sobel (1994) who wanted Wolfensberger to document his assertion that many drug therapies were dangerous and that they killed and maimed countless of their purported beneficiaries. Wolfensberger (1994) had written in an earlier article that "The use of prescription psychoactive drugs probably accounts for 100,000 premature deaths a year, considering how many people are on such drugs, the doses, and the duration. Of course, one will rarely see the drugs listed as the cause of death. More likely, one will see entries such as pneumonia or heart failure, which themselves were caused by the drugs." It is my opinion (and you will be able to read for yourself) that Wolfensberger responded to this challenge in spades and gave them much more than what they had bargained for. O'Brien's (1994) synopsis points out that this controversy is about two issues: On the one hand, are Wolfensberger's assertions true? And

if so, what does the dispute about the credibility of Wolfensberger's evidence disclose about the situation of socially devalued people (p. 377)? This article will address the first question; Wolfensberger had already addressed the second in his "Signs of the times" article that also appears in this issue. However, I will attempt to discuss what it all means for Social Role Valorization (SRV).

Pharmacotherapy is ubiquitous

Wolfensberger's (2004) Reply to Levitas et al. is not an "SRV" critique of drug therapies, but it is nonetheless relevant to SRV practitioners and to others who compete against the medical model. Pharmacotherapy is a competitor to SRV inspired interventions, and ensconced as it is in the medical model, it is a high powered, high status and immensely rich competitor. Today, people willingly seek out medical practitioners in the hope that they will find some miraculous magic bullet that will cure all that ails them. Countless billions of dollars are spent yearly, dispensing drugs to hopeful patients and researching and marketing new drugs for just discovered or even not yet discovered maladies. New drugs are hailed in the popular media as miraculous: One need but remember the multimillion dollar hype around Prozac; here was certainly nirvana in the making (Breggin & Breggin, 1994). The ethos of the age is well captured by the following quote from the *National Post* (Eversen, 2001) article on bed-wetting "Boys who fidget too much get Ritalin. Kids with earaches or sniffles get penicillin. Shy or nervous kids get Prozac. And now, a drug for bedwetting" (p.A1).

Of course Mellaril is but one of the many drugs available to doctors who come into contact with people across the Western World. There are literally thousands of different medications in the medical pharmacopoeia to choose from. For at least 25 years now, medical treatment usually means the prescription, in

90% of cases, of a drug therapy of one kind or another (Siler, 1978). In 1999, Canadians spent \$8.3 billion CDN (or about \$5.5 billion US), which converts to over 272 million prescriptions for Canada's population of close to 30 millions (Picard, 2001). In the USA, retail sales of prescription drugs have gone from 78.9 billion dollars in 1997 to 154.5 billions in 2001 (Moynihan, 2003a). Indeed, for 2001, money spent for medication represents 12% of all health care costs in Canada, up from 5.8% in 1980 (Romanow, 2002). Prescribed drugs are used to treat all manner of behavioral, educational and even social problems. Thus drugs get hyped to cure impotence (Carney, 1999), bed wetting (Evenson, B. 2001), baldness, shyness and much much more (Branswell, 2002). Indeed, some prescription drug enthusiasts and much media hype suggests that some new modern drugs, such as Prozac and Ritalin, should be taken by most people to enhance their alertness and drive (Hall, 2003). Dr. Peter Breggin (1994), in his bestselling *Talking Back to Prozac*, discusses media and particularly television coverage of the Prozac phenomenon. "Another show raised the question of unfairness. Because of their increased alertness and drive, weren't Prozac users getting an unfair advantage in the business world?" (p. 5).

Pharmaceutical companies spend millions on advertising but have also developed other forms of social influence to convince one and all of the necessity of drug therapies. Moynihan (2003a), writing in the *British Journal of Medicine*, documents the increasing entanglement of drug companies and medical practitioners. In a survey of a number of countries, 80 to 95% of doctors have regular contacts with drug representatives and are educated to a very positive view of medications, and their prescribing habits are less appropriate as a result. Gosden and Beder (2001) document an "astroturf" strategy of advocacy by drug companies. *Astroturf* is the creation of artificial

grass root organisations to promote drugs and the theories behind them, in effect, a strategy of putting the words of drug companies in someone else's mouth, someone who, on the face of it, has no interest in the matter. Thus, survivor groups, family groups, and parent groups of so called mentally ill individuals are extensively funded and supported by drug companies in order to garner their support and to support the chemical agenda. These front groups such as the National Alliance for the Mentally Ill (NAMI), and the American Council on Science and Health, effectively lobby government as proxies for industry. Such organisations receive extensive support from drug companies which stand to profit handsomely by linking their goals to what they hope to have defined as a grass roots popular movement. The authors point out that the flip side of this is rather less innocuous: "The policy intention . . . is to weaken civil liberties protections in mental health laws in order to increase the number of people eligible for involuntary treatment" (page 155).

The success of the medical model and of drug therapies is well illustrated by the amount of money spent on health care. Recent newspaper articles in Canada show that the expenditure on medication increases 10% every year when inflation rates are at the 1 or 2 per cent level. Health care and medical services take up 9% of the Canadian Gross Domestic Product (GDP) and almost 15% of the US GDP. In both countries we are constantly warned about a crisis in health care funding with waiting lines at emergency departments and the lack of availability of ever costlier and more complex high tech equipment and high cost drugs. The Ontario government spends on health services more than 15 times what it spends on social services. Not surprisingly, when all new available dollars go to health care the result is that social services are effectively scaled back. Thus, public funding for community residential services, supported

employment, citizen advocacy, have either been reduced or frozen for the past ten to fifteen years.

Making problems into diseases: The so-called organic basis of mental, behavioral and social problems

The citizenry, patients and their families have been socialised into accepting that day-to-day problems are illnesses and that chemicals will do the trick. Doctors are also indoctrinated into believing that drugs are the necessary and only hope, by first being indoctrinated about the organic basis of so called "mental illness." Leo and Joseph (2002) in their review of the most widely used and cited textbook on neurology show that the chapter on schizophrenia written by a Nobel Prize winner misrepresents the evidence for the biological basis of schizophrenia: The controversial nature of the findings, the less than robust arguments in support of the thesis, and the alternative (and more compelling) hypotheses are not even presented. Doctors in training reading this chapter (and many have) come away with the idea that the theory is fact and that there is only one course of treatment: Drugs.

The *Canadian Press* recently introduced a story with the following: "Drug companies are 'disease-mongering' in a bid to sell healthy consumers pills for a range of problems such as baldness and shyness, doctors say. 'There is a lot of money to be made from telling healthy people they are sick,' say the authors of a series of articles in tomorrow's *British Medical Journal* (BMJ). 'What for many people is a mild functional disorder—requiring little more than reassurance about its benign natural course—is currently being reframed as a serious disease attracting a label and a drug, with all the associated harms and costs'" (Branswell, 2002). The article referred to in the *BMJ* was titled "Selling sickness: The pharmaceutical industry

and disease mongering" (Moynihan, R., Heath, I., and Henry, D., 2002). They document how the pharmaceutical industry has medicalised human problems in order to expand markets and increase profits. Some of the tactics include a) claiming that certain conditions are frequent and wide-spread (rather than exceptional), thus readying people for, indeed getting people to expect, certain diagnoses; b) turning ordinary ailments into medical problems; c) interpreting mild symptoms as serious; d) interpreting personal problems as medical; e) turning risks into diseases. What all of this amounts to is the marketing of fear and of a new and profitable/costly way of viewing the human condition.

A respected research psychiatrist speaking at a recent Ontario child welfare conference affirmed that over 20% of Canadian youth had "clinically important" mental disorders that required professional treatment. In sombre tones he told us that governments had to fund more mental health services to reduce the suffering, otherwise the financial and social burden of this class of kids could have a major deleterious impact upon Canadian society. Much of what psychiatry has to offer these kids and their families is chemical.

Drug companies have become very effective and they have achieved remarkable returns on their advertising (not to mention research) investments. But like the drugs, these strategies have had deleterious secondary effects that we will explore presently. However, it is worth mentioning that once people are socialized into believing that any problem is an illness, they will in turn see doctors more often and turn up in hospitals more frequently, thus leading to the health care funding crisis where more and more of the Western World's gross national product is devoted to unproductive medicine. Prescription drug costs end up being the tip of the iceberg.

Leifer (2001), Schwartz & Begley (2002), Szasz (1988 and 1996), Whitaker (2002), and Valenstein (1998) all compellingly argue that

the case for the organic basis of schizophrenia, the prototypical psychiatric malady, has yet to be made and more importantly that it probably never will. Very simply, the brain is too complex and too interactive with the environment and with itself for finding relationships between a specific problem and a specific brain process. Schwartz & Begley (2002) document the incredible complexity of the brain and how its structure is constantly changing with every new experience. They report on the brain's lifelong plasticity and recent surprising findings of neurogenesis (the production of new brain cells) throughout life. Add to that 50 or more known neurotransmitters (Valenstein, 1998) and it becomes obvious that the wild claims of pill pushers and some brain researchers should at the very least strain our credulity.

As for the genetic basis of "mental diseases" such as schizophrenia, Barry Commoner's (2002) review of the Human Genome project reports that researchers, contrary to the triumphant press reports, did not find what they expected. Indeed, it would seem that we share about 99% of our genes with the common mouse. It had been proposed as central dogma that DNA genes control the proteins that control the different amino acids that give rise to our different traits. This linear theory suggests that "in each living thing there should be a one-to-one correspondence between the total number of genes and the total number of proteins" (Commoner, 2002). However, because there are too few genes this can no longer be the case. Commoner also suggests that genes are even more interactive and dynamic than had been first believed. The results of the Human Genome Project should at the very least temper the enthusiasm of those in human services who embrace the notion of the genetic or physiological basis of human problems such as schizophrenia, ADHD, depression, etc. Joe Tsien, a leader in brain research is quoted as saying: "Frankly speaking, we still know so

little, we know no principles, no operating code for memory. We know a lot of genes, but we don't have a coherent picture, and I think that is the problem with the whole area of therapeutic research and development" (Hall, 2003 p. 65).

There is a materiality to life, and biology, physiology and genetics are part and parcel of the human condition. However, such a statement is essentially meaningless. The human genome, interactive as it is with the environment, is so complex that it is quite unlikely that we will be able to identify the specific locus of any individual problem or given trait. Moreover, the individual is not the static result of his genetic inheritance but rather a dynamic continuously changing person whose genetic endowment, brain structure and chemistry are tempered and prodded by life experiences and life conditions. Indeed, many behavioral and mental problems such as schizophrenia, hyperactivity and the like, are in and of themselves complex and multifaceted and quite untraceable to specific genes in the genome or cells and "circuits" in the brain (or, for that matter, specific past experiences or even sequences of events), thus multiplying even further the ultimate causal complexity. Thus, the genetic origin of the organic basis of mental and behavioral problems rests on very flimsy evidence.

"Although it would be perfectly reasonable to posit that genes determine the brain's connections, just as a wiring diagram determines the connections on a silicon computer chip, that is a mathematical impossibility. As the Human Genome Project drew to a close in the early years of the new millennium, it became clear that humans have something like 35,000 different genes. About half of them seem to be active in the brain, where they are responsible for such tasks as synthesizing a neurotransmitter or a receptor. The brain, remember, has billions of nerve cells that make, altogether, trillions of connections. If

each gene carried an instruction for a particular connection, we'd run out of instructions long before our brain reached the sophistication of, oh, a banana slug's. Call it the genetic shortfall: Too many synapses, too few genes. Our DNA is simply too paltry to spell out the wiring diagram for the human brain" (Schwartz & Begley, 2002, p. 112).

However, even when there is clear evidence of brain damage, as with Alzheimer's disease, there is no necessary link with behavioral or mental problems. David Snowdon (2002) describes an ongoing study of aging in a community of the Sisters of Notre-Dame. He writes that brain pathologists have to wait till after a person's death to diagnose with any kind of certainty that a person has the brain lesions that are associated with dementia. Before a person dies "there is no definitive test—no blood workup or even brain scan—that can provide absolute certainty in a living person..." (p. 88) that he has or hasn't Alzheimer's. Indeed, though there is a strong correlation between the organic pathology associated with Alzheimer's on the one hand, and dementia and bizarre behavior on the other, there is no necessary link. "Sometimes Markesbery [a brain pathologist involved in the study] finds little evidence of Alzheimer's in a sister who had the classic symptoms of the disease. And sometimes brains from other sisters who appeared mentally intact when alive show extensive evidence of Alzheimer's" (p. 86).

The above also highlights the problematic aura of certainty that seems to cloud the diagnostic enterprise of modern mental health and psychiatry. Gawande (2002) documents how notoriously unreliable diagnosis can be for clearly organic problems such as heart disease and other physical problems, even using such techniques as the electro-cardiograph (ECG) or the newer computer enhanced imaging techniques. Maddux's (2002b) debunking of the atheoretical Diagnostic Statistical Manual

(DSM) should confirm that the reliability of a psychiatric diagnosis and its link to any organic cause is in an inverse relation to the pontificating certainty of a given psychiatrist.

Pharmacotherapy is at best controversial

If the theories of genetic and organic causes of mental and behavioral problems rest on very flimsy evidence, one should not be surprised that the chemicals that are used, in keeping with such theories, are not really effective. Shapiro and Shapiro (1997) in their massive overview of the placebo argue that despite a marked improvement in medical research generally, the same cannot apply to mental health or psychiatry. Indeed, the authors document how mental health and psychiatry are particularly faddish and that research methodology in these fields lacks rigour (see also Leifer, 2001; Shean, 2001; Valenstein, 1998; and Whitaker, 2002). It is not, of course, that there is no research; quite the contrary. However, the authors conclude that not much is known about mental illness today after all this research. They describe the drug therapies of today as the current logical endpoint in the evolution of ethically questionable and theoretically dubious somatic methodologies used over the past century which include insulin coma, electroconvulsive treatment, psychosurgery, and more recently the use of stimulants, antipsychotic drugs, major tranquilizers and antidepressants (see also Breggin, 1997; and Whittaker, 2002).

Shapiro & Shapiro (1997) and Kirsch and Sapirstein (1999) report on the many studies that reveal how the effect range of antidepressant drugs closely mimics the effectiveness range of placebos. Moreover, Shapiro and Shapiro (1997) question the value of methodologies that compare inert placebos to active drugs when in fact active placebos should be used. Inert placebos tend to take the "blind" out of double blind studies, suggesting that

placebo effects are usually underreported. The Shapiros add that given current knowledge, "the distinction between antianxiety, sedative, and hypnotic effects is unclear and is largely associated with the dosage" (p. 95). There is very little to distinguish between many different drug types. Thus the theories that underlie the specific usages of such drugs are to say the least unclear.

Alvaro (2002) points out that new theories must be met with healthy skepticism, especially when such theories are constructed upon unverifiable knowledge claims. Occam's razor requires that one should always prefer the explanation that is the most economical; or, in other words, the simplest explanation until disproven is the best. The very complexity and interactivity of the brain and the human genome mitigate against such theories being useful. Alvaro goes on to point out that Occam's razor is not a metaphysical dictum but rather a methodological tool that obliges one to not only be aware of what one knows but also to be aware of what one *doesn't* know. Occam's razor requires that we can only modestly propose in a theory the things that we know and those that we can relatively easily ascertain, rather than suggest causes and effects that are beyond the scope of our comprehension and, most importantly, experimentation. This certainly applies to theories that purport to (causally) link organic and genetic phenomena to behaviors, thoughts or other life problems.

The prescription and use of drugs and other somatic treatments requires that we believe such theories (Valenstein, 1998). The general public might be able to claim ignorance for their beliefs, but for experts it requires a remarkable degree of self-delusion (Whittaker, 2002). All of this recalls Wolfensberger's (1994) critique of modern life. One of the signs of the times he noted was the "The 'Crazification' or 'Insaniceration' of the People of Modernism" where he asserts that "More and more, I have noted lately that even among educated people,

arguing issues in terms of evidence has become an irrelevant exercise. They simply assert as truth what they want, or what they wished the truth were, or what they have to mouth in order to be accepted by those groups to which they want to belong" (p. 25).

The medical model has so permeated our modern culture that despite the outlandish nature of the theoretical schemes that undergird somatic treatments for problems of living, a huge proportion of the population uses psychoactive and other forms of medications in circumstances where other means would be undoubtedly more effective and valid. However, this simple observation suggests that the medical model and its appurtenances are highly valued, even desired, and convey powerful positive imagery.

Image enhancement and prescribed drugs

When a child, youth or adult is diagnosed with some form of difficulty or problem, not surprisingly one of the immediate responses of the medical establishment, of social workers, of parents and so many others is, "There must be a drug out there that can help?" Drug therapies are so pervasive that they constitute today a valued and even the most widely used method of intervention to deal with problems of living. After all, with former US presidential hopeful, Robert Dole, hyping Viagra in the popular press (Carney, 1999), it is not surprising that on the whole drug therapies have very few overt imagery problems that affect massive public support and utilisation.

From an SRV perspective, we need to spend some time examining the imagery "problems" of pharmacotherapy, where every problem becomes sickness and disease. Certainly the imagery concerning drug therapy is confusing: Chemicals developed by high powered pharmaceutical companies are enveloped by the high gloss of science. Breggin & Breggin

(1994) describe the complex theory that undergirds Prozac where it selectively "blocks or inhibits the reuptake process for serotonin... (which leads to) increased firing of nearby postsynaptic nerves... (that then leads) to the improvement of mental disorders, including depression" (p.23). The fact that this is scientifically unlikely (Breggin & Breggin, 1994; Valenstein, 1998) does little to diminish the patina of science and the confidence of the public and professionals. Science is high religion today, and faith and hope are foremost in the methodology of medical and other human services. Indeed, expectancy effects—placebo—are always present (Shapiro and Shapiro, 1997) and explain as much as 85% of any given prescription drug effects (Kirsch and Sapirstein, 1999; Shapiro and Shapiro, 1997). Imagery is powerful and feeds back into the purported competency impact of drugs. The potency of a drug lies mostly in the imagery that surrounds it. This seems to suggest that such imagery is positive, particularly since it is ensconced in the image of an organic wound that can be cured.

The new pervasiveness of the medical model, its great public acceptance as the way of "understanding" suffering and life problems requires a more sophisticated analysis. Indeed, it could be argued that the "sickness" model does not so much devalue as make invisible the more appropriate causes and thus targets of our solicitude. Wolfensberger and Thomas (1983) write that imagery conveys *information* to others about social status, social roles, similarity to others, competence, and other personal characteristics (p.36-37). Though prescription drugs are prescribed quite democratically, some drugs seem to be given more often, and in more combinations to some groups than to others. Ritalin cuts across most social boundaries but it is mostly used with so-called hyperactive children and youth, who seem to mostly come out of poor dysfunctional families (Breggin, 1998). The use of drugs with vulnerable classes

makes the treatment seem normative. It creates the illusion of "normalization" and disguises the great differences in living circumstances and experiences that are the more likely causes of problems and personal difficulties.

The medical model has clear advantages over the developmental model in terms of imagery conveyance. Very simply, if the problem is organic, genetic or medical, then the person (and immediate social environment, including parents) can be held blameless for the problem. There is no doubt that the claim that alcoholism is an illness and genetically based has been a great solace to many individuals and their families. As Vaillant (1995) points out, alcoholism is a very complex phenomenon that defies being reduced to an organic explanation. The same can be said for so called hyperactive, ADHD children (Ravenel, 2002). The organic explanation of their misbehavior and lack of internal controls means that the poor parenting skills of their parents, and the poor classroom management skills of many teachers, are never called into question.

It would seem that Western culture has been effectively socialised into accepting as fact that organic, material causes are at the heart of most if not all life problems. Not surprisingly, disease-illness mongering is a multibillion dollar industry that preys on our desire to be relieved of blame, the responsibility of effort, the exercise of will and self-discipline and especially solidarity with others who are wounded. But drugs are widely used and universally accepted and this suggests that the overt imagery is positive, which is why the pharmaceutical industry spends millions of dollars on advertising, and this imagery manipulation adds to the very potency of drug treatments. Indeed, studies show that, from 1981 to 2002, antidepressant placebos seemed to increase in potency, as the general population overcame its early skepticism and reluctance to use medication for mental problems (Brean, 2003).

Drugs and competency enhancement

Many if not most drug therapies make claims of competency enhancement. Drugs are prescribed to reduce debilitating—competency inhibiting—behaviors or thought patterns. However, competency diminishment (of which deathmaking is an extreme case) is also an SRV issue, and the simple fact is that most if not all drugs exact an enormous competency cost from their purported beneficiaries. Indeed, Wolfensberger makes it very clear, quoting from drug compendiums and the establishment literature, that countless drugs are indeed toxic and very dangerous; not only do they diminish faculties and competence but they accelerate death and even in many situations produce death. Wolfensberger's critique is far reaching and almost overwhelming. But his critique is not singular. The psychologist, researcher, and well known author Martin Seligman (1993), a former president of the American Psychological Association with recognized establishment bona fides, devotes a whole chapter to a relatively devastating critique of drug therapies. Seligman also provides evidence about competency diminishment and deathmaking, arguing that, on the whole, drug therapies for social and psychological problems only mask symptoms and do not provide anything that might look like a cure. Seligman's point is that cognitive or pedagogical modalities, though more demanding, are often more effective and long-lasting.

Indeed, as Wolfensberger and Seligman and so many others have pointed out, many drug therapies came about accidentally. By and large, much of the medication that is today prescribed for problems of living, psychiatric illnesses and the like were first developed for other purposes. Seligman points out that antipsychotics were initially developed to combat asthma. Valenstein (1998) writes that chlorpromazine first came about through the

work of chemists with the Geigy Corporation who were working on the development of synthetic dyes. Indeed, chlorpromazine is a derivative of coal-tar and was first developed as a synthetic dye. (It would seem that many pharmaceutical companies originated as chemical companies interested in developing synthetic dyes, but found more profitable endeavours for their toxic products.) "In the course of doing research on phenothiazines and synthetic dyes, it was discovered that some of these compounds also had biological properties potentially useful in medicine" (p. 21). Chlorpromazine which is a phenothiazine was first found to be an antihistamine. Antihistamines decrease muscle tone, reduce nausea, increase sedation and in some instances induce mild euphoria. Initially, these were viewed as problematic side effects. However, a number of European scientists saw that such a chemical had potential uses first as an anaesthesia and then, later, as an antipsychotic as it seemed that this drug reduced the salience of hallucinations and delusional thoughts in schizophrenics. Chlorpromazine was eventually marketed as *Largactil* (a drug of many actions), *Mellaril* and *Thorazine*. The impact of these drugs was considerable. Though not universal on all patients, some researchers described its impact as a veritable medicinal lobotomy as it induced hibernation and so on. Early research studies reported that "some patients appeared heavily drugged and seemed indifferent to what was going on around them" (p. 28).

In many respects, the purported benefits of many of these drugs are nothing but secondary effects. Seligman posits an interesting theory about how drugs work, which shows the extent to which he, at least, views them as dangerous competitors to other intervention modalities.

"You might entertain the naïve image that the drug swoops down on the invading foreign disease and kills it, like a falcon attacking a rabbit. I have a different image

of how a lot of drugs work, and while controversial, it may help you understand the seamy side. In my image, drugs are themselves foreign invaders, just like diseases. Your body regards the drug as a toxin, and your natural defenses are mobilized to fight it off. A side effect is that these mobilized defenses happen to kill off the disease. The true side effect of a drug is to arrest the disease. The main effect of the drug is to produce the unwanted lesser illnesses, euphemistically dubbed side effects" (p.37).

Indeed, the first and foremost effect of most drugs is competency diminishment and death acceleration.

And make no mistake, these drugs do harm. Whitaker (2002) relentlessly documents how drug therapies are the natural continuation of previous somatic therapies such as insulin shock, electro-shock and lobotomies, and that these were built upon other less subtle tortures including the tranquilizer chair, the iced water bath and many others.

"In 1953, when Smith, Kline & French chose Winkelman to be its lead investigator on its initial tests of chlorpromazine, surgical lobotomy was still seen as a good thing. It was the therapy that chlorpromazine had to measure up to, and when Winkelman reported his initial results, in the *Journal of the American Medical Association* on May 1, 1954, he praised the drugs for being similar in kind. The drug produced an effect similar to frontal lobotomy, he said approvingly. It made patients immobile, waxlike, and emotionally indifferent" (p. 154).

Moreover, over time, patients using these drugs develop very disturbing side effects, some of them totally irreversible. Patients often showed signs of Parkinson's, akathisia, tardive dyskinesia, and a whole host of other physical difficulties, some of them life threatening. Whitaker (2002) argues persuasively

(Valenstein [1998] echoes this argument) that what we today hold as the stereotypic behavior and demeanor of chronic schizophrenia patients is most likely related to the long term effects of very toxic chemicals rather than anything related to their "disease."

The role of *medicine taker* and the developmental model

The role of *medicine taker* seems to stretch beyond the sick role. It might even be argued that we are coming to view the *medicine taker* role as one that engages the person in preventing being cast into the sick role. Drug companies are at work shaping the image of drug taking so that it becomes viewed as performance and competency enhancement, and illness (or at the very least symptom) prevention. We invest increasing significance, money and time in the regular rituals of taking all kinds of chemicals including vitamins, minerals, so-called organic preparations with the hope of improving health, performance and life span. All kinds of preparations, some of which were once simply food and beverage (i.e., herbal teas, red wine) are now being taken for "medicinal" reasons. However, just as the *client role* is different for devalued, in contrast to valued, persons (Wolfensberger & Thomas, 1994), the role of *medicine taker* is transacted in fundamentally different ways and for different reasons. One of the most important differences resides in the control that the person exercises in taking drugs. Valued persons take up the role of *medicine taker* with the (often misguided) belief of health, performance and life enhancing benefits. Devalued persons are often coerced into *medicine taking* and it is viewed as a condition of their continued citizenship. For the devalued *medicine taker*, taking a drug, or following a drug regimen, is often the condition for being admitted into a classroom, or for leaving a psychiatric hospital. The chemicals ingested by valued persons may also do

damage, but insulin for instance, extends the life of the diabetic, whereas many psychoactive drugs reduce life expectancy and competence. Valued persons who have been misled by their doctors and advertising often direct their reactions to the courts. Ray Moynihan (2003b) documents how recent research is showing that hormone replacement therapy (HRT), which has been dogmatically used with (post) menopausal women for over thirty years does not statistically improve quality of life, but does increase the risks for cancer, heart disease and dementia, among other things. Not surprisingly, one drug manufacturer that has made as much as 3 billion dollars (US) a year had over (in May 2003) 16 class action suits filed against it in the USA alone. We have yet to witness similar empowered actions on behalf of people on long term psychoactive medications.

From an SRV perspective, when one wants to make the case for powerful, albeit effortful, pedagogical SRV-coherent interventions, one must realize that alternative and facile drug therapies will always be recommended as an alternative. The modern mind, as it is, with its preference for cutting to the chase and getting quickly to a solution—its here-and-now-ism as suggested by Wolfensberger (1994)—seems to always prefer the quick and in this case the nasty solution of drug therapies. "When materialism combines with a very individualistic pursuit of what is sensually gratifying, then we get 'here-and-now-ism': A concern not just with myself and my material and sensual wants, but with me and my wants this very minute, in disregard of others—and even of myself in the future" (p. 20). Before advocating for alternative SRV sympathetic intervention strategies, we need to take heed of Wolfensberger's critique of this well entrenched competitor, and the culture that seems to yearn for its seductive powers.

The developmental model has long been at odds with the medical model. Philip Roos in his 1971 article, who, by the way, attributes the

developmental model to Wolf Wolfensberger, attempted to demonstrate how the developmental model was in fact complementary to the medical model. However, more recently, Smith (2002) argues that there is a fundamental incompatibility between socio-pedagogical interventions and the medical model. Indeed, service schemes such as SRV and other socio-pedagogical approaches within the realm of the developmental model are in a great competition with the medical model for dominance in the service structure, for the availability of scarce resources, particularly funding, and even for the hearts and minds of the general population.

Surprisingly, for truly organic and medical problems, the developmental model is of great importance. Albert Bandura's (1995; Maddux, 2002) self-efficacy, which is clearly in the developmental model, has had a great deal of impact on medical health services. Heart disease is organic and yet the best treatment is developmental in nature. Heart patients are supported and trained in making important life style changes—cigarette cessation, regular exercise, different eating habits, and relaxation—which are nothing more than the acquisition of new life competencies. Thus, it is even more surprising that problem areas that are not clearly organic or medical have become totally captured by the medical mind-set. Heart patients or the victims of strokes or automobile accidents and the like go through extensive regimens of training, rehabilitation, and competency acquisition. Yet, for literally thousands of so-called hyperactive children, the treatment of choice is a pill, and teachers, parents, social workers, and the children themselves are thus exempted from making the effort that promotes skill acquisition and the learning of self-control.

Moreover, pedagogy, practice and effort are known to produce organic changes, even in the brain. Schwartz and Begley (2002) document how pedagogical and developmental model

approaches have been shown to enhance neuroplasticity and even neurogenesis. "Neuroplasticity refers to the ability of neurons to forge new connections [new synaptic connections between neurons], to blaze new paths through the cortex, even to assume new roles. In shorthand, neuroplasticity means rewiring of the brain" (p. 15).

It would seem that the brain rewires itself continuously based on our experiences. The evidence of neuroplasticity counters the prevailing notion that the brain is fixed and immutable at puberty and that from puberty on the brain degenerates, leading us eventually into senility and death. In fact, neuroplasticity occurs throughout life; it occurs quite naturally because of experience, because of exposure to new stimulation, to new environments, and leads us to produce all sorts of new behaviors. Moreover, research shows that the brain is self-healing in a number of ways. First of all, there is considerable neurogenesis throughout life. Neurogenesis is the creation of new neurons (brain cells). It had long been thought that the brain produced no new cells after birth (or at least after puberty). But now researchers agree that there are three major phases of neurogenesis: One of course is in the womb, the second during puberty, and the third major moment of neurogenesis is at the onset of adulthood. However, Schwartz and Begley report that researchers have found evidence for neurogenesis throughout life (see also Gage, 2003). A recent special issue of *Scientific American* (September 2003) is devoted to the veritable revolution in brain science which includes numerous reminders that it is still a research area in its infancy.

There is also considerable evidence now that the brain, through rewiring and reutilization, can overcome considerable brain damage. For instance, damage to a portion of the right side of the brain will lead the left-brain to take over some of those same functions. Parts of the brain that are left unused because of

a loss of function, for instance because of blindness or deafness, will lead the brain to repopulate those brain areas with other functions. For instance, it is now well established that the reading of Braille with the index finger is processed in the visual cortex that, of course, has been abandoned because of loss of eyesight.

The neuroplasticity of the brain is very good news and is quite in keeping with the developmental viewpoint of human functioning and human progression. However, the most intriguing part of the Schwartz & Begley book is how willfulness, mindfulness, volition, and attention can be used quite effectively to rewire the brain. Much of what we do, of course, is habitual and almost autonomous. However, when we pay attention to things or when we direct our attention to certain activities or to certain features of a picture or of an environment, brain functioning is incredibly enhanced. Tying one's shoelaces, of course, is mostly automatic, and when we do it a small portion of the brain is firing away allowing us to do it. However, if we pay attention to the task, the amount of brain circuitry that is devoted to the task increases dramatically. Indeed, simply *imagining* doing the activity (the mental activity only) fires up the same parts of the brain, suggesting that imagining things (imaging them in our minds) is a very effective way of practicing. Indeed, with stroke patients, it is now used as an important part of therapy with patients being invited to concentrate and imagine using limbs that are now paralyzed. Thus, stroke victims are trained to develop mindful effort in an attempt to start reusing limbs that had previously been thought to be paralyzed.

It then would seem that through sustained conscious effort, one is able to relearn to use limbs that have been lost to paralysis, and not so surprisingly to change one's thought patterns as with an Obsessive Compulsive Disorder or depression. Researchers are only now

discovering how far these findings will go in allowing individuals to reclaim lost functions.

It's important to note that neuroplasticity is very consistent with the developmental concept of resilience (Cicchetti, 2003; see also Lemay & Ghazal, 2001). In fact, they go hand in hand. Resilience starts with the notion that negative childhood experiences are not necessarily devastating throughout life, that positive development can follow adversity. What we now know about brain functioning and, particularly, neuroplasticity supports this. This notion of mindfulness and attention is also in keeping with the personal characteristics that many resilient people have, that they are able to *turn their minds* to the future and not dwell on the past. It's never too late to learn; it's never too late to go on to other things. All of this is very consistent also with the previously mentioned findings of the "Nuns' study" (Snowdon, 2001) where individuals with significant brain damage due to Alzheimer's were nonetheless able to lead lives with no sign of dementia: It would seem that because of their engaged intellectual activity, they are able to use other unaffected parts of the brain to get on with their cognitive lives.

The description of how stroke patients overcome paralysis and Obsessive Compulsive Disorder patients overcome obsessive thoughts tells us very clearly that none of this means that there is an easy fix for these problems; quite the opposite indeed. It would seem that mindfulness requires a lot of effort, a lot of repetition and, eventually, a mastery over one's self. This is remarkably good news that should bolster the effectiveness claims of SRV and other developmental model approaches.

The evidence suggests that somatic treatments are ineffective and that theories that purport to link behavioural and mental problems to organic causes are very simple minded. More importantly, the evidence also suggests that developmental/pedagogical approaches are very effective in treating truly

organic diseases, including damage to the brain. But drug companies and psychiatry have been singing a seductive siren's song that, despite very poor science, seems to have convinced a large portion of society that there are simple and facile solutions to the problems of daily life. Modern psychiatry and drug companies tell us that we are the victims of our genetic endowment or of faulty wiring and chemicals in the brain. This fits in with our culture of victimology that, as Seligman (1993) points out, has led to a massive reduction in the ethic of personal responsibility where individuals do not feel compelled to make changes in their life-style and so on.

The developmental model starts with the premise that each individual has important reserves of potential that can be, with effort and intention, marshalled in the cause of overcoming problems and of positive development and self-improvement. SRV's position is certainly a more dignified and uplifting perspective on the human being but unfortunately not as compelling as a magic bullet cure for all that ails you.

Conclusion

In preparing for this issue, I asked a respected research psychologist, who has done much work in pharmacology at a local university, to review Wolfensberger's critique of drugs. A few days later he e-mailed me his verdict. He suggested that the bibliography was outdated and relied too heavily on popular media reports. He then suggested that, of course, it would be best not to use drug treatments, but that there were simply no alternatives available. But there are. SRV is a very powerful alternative, even when inconsistently applied, as the history of the last forty years in mental retardation testifies.

Wolfensberger recently pointed out (2002, p. 12), that an important event in mental retardation over the past 30 years was the

departure of the medical model and thus of doctors, psychiatrists and nurses from the lives of many if not most mentally retarded persons. However, the recent flurry of interests and research in the so-called dual diagnosis (mental retardation combined with mental illness) has led to new confusions and of course to the re-involvement of psychiatry and the accompanying mental health-medical model. Whereas over the past 30 years, the main service modality has been one of improved life experiences and conditions with more or less training, formation, support and accompaniment, we are now today confronted with the re-medicalization of mental retardation. Given the state of our medicalized culture, this should come as no surprise.

Wolfensberger's monograph, that follows herein (pp. 42-66), will serve as a good tonic for those who promote SRV-inspired interventions, and help fight off the *medicine taker* role in favour of the available plethora of developmentally powerful and culturally valued roles that lead to a chemically free good life.

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