HYPOCHONDRIACS LIVE LONGER

and other good news from my experience as a psychiatrist

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The psychiatrist I’m not

“This must all seem very normal to you.”

[pp. 17–28]

As a psychiatrist you have to live with the fact that people have a clear image of your work. Actually, two images. The first is that of a bearded older gentleman, an odd-looking man (if we're being charitable) who dozes off beside a couch on which a middle-aged lady is currently expounding on a midlife crisis caused by a lack of sex. After three years or more, the gentleman awakes briefly from his slumbers, explains to his patient the cause of her suffering (a lack of sex) and then goes back to sleep. He charges something like 900 euros per hour for this, probably more. The man is as incompetent as he is rich. His profession illustrates and proves how decadent our world has become. It could be abolished and no one would miss it.

The second widespread image of a psychiatrist's job is of a white-coated sadist who works behind the closed doors of a mental asylum on the outskirts of town, where the "patients" are all a lot more normal than these prison guards who dress up as doctors and nurses to carry out their duties. The role of the psychiatrist is to go behind the patients' backs and inject or force-feed huge quantities of psychotropic drugs to shrieking prisoners or "patients" tied up in straitjackets. These psychotropic drugs are absolutely useless for curing people's psychological problems and are instead responsible for an infinite range of horrific side effects.

These two images of psychiatrists' work have been copied and reproduced, repeated and perpetuated in art so many times, that they are now seemingly baked into our minds. Year in, year out since it was first

broadcast in 1971, *Tatort*, Germany's favourite TV crime series, has trotted out one or other of these two clichés to its ten million viewers. Even now, it is virtually impossible to pitch a plot involving mental illness to a film production company without replicating at least one common stereotype. What is especially insidious is that these shows stigmatize mental health sufferers in the process because what both clichés suggest is that mental illness is not real and doesn't require treatment.

I spent several years as spokesperson for our clinic. I can't tell you how many requests I fielded from production companies wanting to know who supplied our straitjackets. They said they'd been unable to find anything online. Their disappointment was palpable when I told them that I'd only ever seen straitjackets in movies about psychiatry, never on a real-life psychiatric ward. Maybe they thought we had a secret source. It's awful how some films love to portray how bad psychiatry is — and then condemn it for being bad.

In these films, psychiatry does not help a single person. They only ever show healthy people getting sick, and the mentally ill being plunged into even greater suffering. This is such infuriating nonsense because however hard our work may be and whatever its limitations, we are able to do many parents good, and often a great deal of good. If these film clichés and clichéd films deter even one suicidal patient from going to see a psychiatrist, then that is an individual we'd have preferred to help.

I have some mathematicians and physicists in my family, and there are probably as many mathematicians and physicists combined in Germany as there are psychiatrists. Yet no one has preconceived notions about their work or about the kind of people that enter these professions. We, on the other hand, face not only preconceptions about our work, but also a multitude of preconceptions about psychiatrists themselves. One particular idea stands out: we're all mad.

Despite their poor reputation, preconceptions have a surprising number of advantages. We'd like to imagine we're different, but almost all of us look at the world through the prism of our preconceptions. Rather than forming our opinions after digesting all the available facts and information, we judge people and situations based on our prior experience. We do not ruminate for hours about whether we should engage with a drunkard's reasoning against the relativity of time. No, we get as far away from him as we can. It isn't impossible that he has some earth-shattering insights to share with us, but we are prejudiced against him and the opinions he is spouting in

his present state. Preconceptions save us a great deal of time that we would otherwise spend observing and analysing.

I once had the honour of giving the final lecture in a psychiatry course for a whole year group of medical students. I presented film extracts from *The Simpsons* that featured various psychological disorders and explained the diagnostic categories, my aim being to look more closely at what we'd leant over the past week while also having some fun. The students seemed to have enjoyed the presentation, so I offered to answer any outstanding questions related to their forthcoming exam. Any questions that had cropped up over the final weeks of the course and which the students hadn't been able to ask. After a long silence, finally a student in the back row raised her hand. She stood up and asked me, "How come all psychiatrists are wacky?"

In defence of the rest of her year group, I ought to note that most of them were embarrassed by this question. Not as embarrassed as I was, though, and it took me a few seconds to control my anger and resist my desire to walk out. She had basically demonstrated, in several ways, that she hadn't achieved the course goals. First, she clearly hadn't met enough psychiatrists who make their way in life with a minimum of fuss. Second, she hadn't grasped that mental disorders, like any other illness, shouldn't be used to stigmatize people. And third, I wondered if she shouldn't actually have said "wacko" because that was the word people used when I was growing up to refer to a mad person rather than just someone who was eccentric. But I wasn't going to start arguing about semantics with my young colleague, as that would probably have just confirmed her suspicions.

I find it unlikely that representatives of other professions have to listen to such blatant and crass expressions of resentment. Besides, we should always be aware when preparing for written exams that practically every statement about human affairs which features the words "always, "all", "never" or "none" is false. I remember it this way: "Sentences with always, never, all and none, are all always never right; none of them is." It may not be the most elegant formulation, but slightly flawed mnemonic devices stick in the mind better than perfect ones. That's another mnemonic device, but I'm sure you'll remember the one with "always" and "never" better, don't you think?

Naturally, I often ask myself why psychiatrists are on the receiving end of such prejudice. I have two theories on this subject. The first is that the preconception is simply wrong, just as most preconceptions about specific groups are wrong when applied to individuals. Also, every psychiatrist

someone knows (preferably a work colleague's niece's first cousin) who behaves or once behaved a little oddly is gladly cited as permanent and universal proof of this preconception. Also, people are very alert to odd psychological behaviour in a psychiatrist, in the same way they would immediately notice a dermatologist's bad skin. Besides, everyone needs a good reason for ceasing to go and see a specific service provider. The hairdresser cuts your hair badly, the greengrocer's vegetables aren't fresh, the doctor's pills don't really work — but how do you criticize your psychiatrist?

You may well be an unkempt individual who takes no notice of the hairdresser's haircare tips, stores the few vegetables you buy incorrectly so they go rotten, and perhaps you do take your anti-cholesterol pills with a cooked breakfast and a huge helping of cream cake, but do you really feel like reflecting on and correcting that? No. So what might be wrong with your psychiatrist? Oh, he's nuts, which is why his advice about your alcoholism didn't help.

My second theory is that we psychiatrists grapple a great deal with the question of normality in the psychological sense. We have learned that the spectrum of psychological normality is much wider than most people like to think. For instance, few psychiatrists would think someone requires treatment just because they're convinced they're a Martian messenger to Planet Earth but are no trouble to themselves or to other earthlings. Apart from the fact that most earthlings would disagree with them . . .

"Oh, come on, it isn't normal!" a patient's relative will huff. "You've got to do something. I thought you were a psychiatrist!"

In this case, however, all we can do is shrug our shoulders. Most people probably don't consider this Martian messenger normal, but it's a kind of abnormality for which we don't feel responsible. After all, we treat patients, i.e. people who are suffering from something, and if someone isn't suffering, then we don't generally feel compelled to help them, whichever planet they come from.

Our dealings with the normality of human coexistence and the people on its margins may, in some cases, have caused some of us to be less ashamed about our own weaknesses. A colleague of mine, for example, would take his dogs, two pugs, along to his practice every day. I like to play "Bop It", a game that involves hitting a fairly ugly-looking lump of plastic, with my patients and I must have other flaws I'm not even aware of. Apply a relatively narrow interpretation of normality and you would probably

come to the conclusion that most psychiatrists are genuinely abnormal. But that is more in the eye of the beholder than in the object being beheld. It is connected to cognitive dissonance, which is a term to which we shall return later.

So who are my patients, if they are neither hobbyless millionaire's wives nor screaming psycho-killers? People often ask me this, and for a long time my spontaneous answer was: "People like you and me." But I noticed that this answer unsettled the questioner. In particular the word "you", I guess. So I tried saying, "Completely normal people." But then that seemed paradoxical, because why would "completely normal people" seek psychiatric treatment?

If there's one word I have a particular problem with as a psychiatrist, it's "normal". It's not even really the word itself, because I'd love to reassure people in general and my patients in particular that they are "normal". The problem for me is that the word implies a dichotomy I don't agree with — a division of things in this world into "normal" and "abnormal". I find this distinction highly problematic and damaging. Who gets to decide exactly where the boundary lies? Neither politicians nor psychiatrists, in my opinion. Politicians need to decide which behaviours are prejudicial to social harmony, and psychiatry is there to help those who suffer from their own behaviour or that of their fellow citizens.

I don't find my patients abnormal, anyway. They have problems and they suffer from mental illness or very difficult circumstances, but they are not abnormal. One particular case has stuck in my memory. A young man had come into A&E with acute psychosis, and I accompanied him to our emergency ward. He was suffering from acute paranoia and hearing voices with which he was also having conversations. A drug addict, he was at risk of finding himself homeless. He satisfied almost every stereotypical idea of someone on the margins of society. I decided to walk him to the ward to make sure he got there. When someone is acutely mentally ill, there is a heightened risk of suicide because the patient finds it hard to cope with this radical change in their perceptions. The patient didn't object to my accompanying him, and he smoked on the way and kept up a constant chatter with the voices in his head.

Shortly before we reached the ward, though, he suddenly looked at me and said, "Where exactly are you taking me?"

“To Ward 155,” I said truthfully and at the same time evasively, as we continued walking towards our destination, the ward doors, now only a few metres away. I was worried my patient might run away when we were within touching distance of our goal.

“What kind of ward is it?” he asked.

“It’s our psychiatry and psychotherapy clinic,” I said. I was determined to make it to the ward.

“There aren’t loads of nutters running around inside, are there?” he said.

“No,” I was able to reassure him. “Just people like you and me.”

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Hypochondriacs live longer

“I know I don’t have a proper illness.”

[pp. 57–66]

Only very good friends get in touch with me for somatic medical problems too — that is, problems other people call “physical”. Yet, on the basis of the research from the last 300 years or so, we psychiatrists assume that the causes and origins of the symptoms we examine lie overwhelmingly in the human brain, which is in turn generally considered to be part of the body. Which is why we consider that we are also able to treat physical ailments, although we are relatively alone in this opinion.

So when someone calls me about a “proper” illness, it is usually to arrange an examination for which the person knows they have time on their side, but that they’d suffer hellishly during that time. “I’m sorry,” these friends tell me, “but you know I’m a bit of a hypochondriac.” Bit-of-a-hypochondriacs generally say they’re real hypochondriacs, whereas only real hypochondriacs say that they’re bit-of-a-hypochondriacs. “That doesn’t matter,” I always reply. “Hypochondriacs live longer.” This is both reassuring and scientifically proven. Someone who is very concerned about their health doesn’t miss the signs of illness and will go and see their doctor in good time. If, in addition, this person resists the temptation to take unnecessary medicine, they really could live longer that someone who coasts through life without a second thought for their health. That’s because, contrary to a perhaps unconscious hope and common belief, hypochondriacs can get sick too. Where necessary, I am happy to arrange the examination they’ve requested.

It is not scientifically possible to understand an unobserved problem. We should therefore always be wary of estimates of unknown cases, apparent figures and phenomena that are hard to prove, because over 51 per cent of interviewees claim never to respond to surveys. There are suggestions, however, from some studies that people with a tendency to hypochondria rarely seek psychotherapeutic treatment. Statistical studies show that 1-4% of people tend to overestimate how bad their physical symptoms are. Which means that there are roughly as many people with this problem as have depressive disorders. By this logic, we psychotherapists should have almost as many hypochondriacs in treatment as people with depressive illnesses . . . But we don’t.

It is therefore very likely that people with hypochondria disorders try to get control of their problems by going to see the doctor even more often, but that these visits cause them to worry even more about their health and only exacerbate the feeling that they’re ill. My somatic colleagues tend not to recommend to these patients that it might be better for them to seek psychotherapeutic treatment. After all, why should they saw off the branch they’re sitting on or insult their patients by suggesting that there’s isn’t really anything physically wrong with them?

Illnesses and disorders do in fact play a very important role because they show us when things cannot continue as they are. This view has developed over the past century and is now mainstream thinking in the medical profession. Illness used to be seen as a phenomenon that pointed from now into the future. What needs to be done differently? How are things to continue? Mental illness can be a particularly valuable indicator in this respect.

Unfortunately, illnesses are increasingly regarded as a balance sheet. Disease is regarded as pointing back from the present into the past, as if it were some kind of criminal record. What did the patient do wrong? Which hobbies and weaknesses have contributed to this “bill” — their illness? Illness is no longer interpreted as fate but instead as punishment — potentially very serious punishment. This view is utterly lacking in empathy. Perhaps Mr Meier has smoked his whole life long, but does that make his severe illness a form of justice?

This same shift is noticeable in how mental illness is viewed. The best-known example is of course burnout. Patients no longer suffer from depression, which would require them to change their lives in the future;

they have already given their all, burnt themselves out, and they are now entitled to be damaged goods. The only reason we cannot detect a “proper” illness in burnout cases is because the evidence has already gone up in smoke, so to speak.

The fact that we have such trouble dealing with these questions may be a specifically German phenomenon. German patients are especially keen on material signs, and if there’s “nothing there” then there must be “nothing wrong”. There must be “something” there and there is, unfortunately, always a doctor willing to feed this suspicion by carrying out another check-up or examining the body with yet another device. Using ever more technology, we scan the body like a crime scene until finally we find the *corpus delicti*—what’s “wrong”. Nice work, detective.

Yet even if there is nothing demonstrably “wrong” with the patient, there is no disputing that he or she is “suffering” from something. If I were to focus on his or her suffering and take it seriously, I would have a good basis on which to recommend psychotherapy. I think doctors and detectives do different jobs, and I’d like to remain a doctor.

I don’t wish to investigate the mistakes the patient might have made. I see my task as a doctor as being to find out with the patient how he or she can successfully continue to lead what he or she considers to be a good life. That is why I have no interest in poking fun at hypochondria. Like so many psychological problems, it can tell us valuable things about ourselves. It is also important to understand that the information conveyed by a hypochondriac disorder hardly ever shows up on X-rays, in blood tests or during the next heart examination.

I feel a strong urge, at this particular juncture, to stand up for the placebo effect! The placebo effect is the precious, free extra impact of all medication as well as being the only positive outcome of medicine that doesn’t work. You wouldn’t remove the juice from oranges simply because oranges taste good, would you? Germans are suspicious of the placebo effect — at least as suspicious as they are of humour. The average German feels somehow cheated, fooled, duped by the placebo effect. Yeah, she’s better, but that was only the placebo effect.

And yet the placebo effect is such a wonderful thing! It isn’t a slimy lover who takes you to a cheap hotel room, lumbers you with an ST, knocks you up, and then vanishes for ever. Nor is it a bank or a one-armed bandit that lures you in with the promise of quick money only to leave you paying

off loans for years. No, the placebo effect is like a wonderful actor who loves you with all his or her heart and is also able to put their love into words. It’s like that delicious dish at a restaurant that really does taste exactly the way Grandma’s always used to, conjuring up lovely memories as well as tickling our tastebuds. Why would we criticize the actor or the cook for their skill? Would we rather have *less* friendly words or a *less* tasty meal?

So what is it that people have against the placebo effect? Without it, no medicines. When a doctor tosses a packet of pills across the table to me with a bored expression on his or her face (I’m picturing a surgeon, obviously), that produces an amazing placebo effect. The doctor is clearly so sure that this medication will have the appropriate effect on my specific symptoms that he or she doesn’t bother explaining very much. When I search for a medication myself online and make every effort to get hold of it, I’ve also created a massive placebo effect for myself. Why should the doctor mention prior positive experiences with this drug? The placebo effect is inevitable, has absolutely no side effects and is only ever beneficial. I’ve no idea what the Germans could have against this. Maybe they find it just too good to be true.

What people have no trouble believing in is placebo’s evil brother, the hunchbacked nocebo. When the doctor says, “Oh dear, I’ve never had a case like yours before. Your worries sound bad. Can we do anything about it? Well, we shouldn’t ever give up hope. Keep hoping. Hang on a minute, I could prescribe you one medici— . . . It won’t help you much though, I’m afraid. I can prescribe it all the same. If you notice anything unusual, stop taking it. Immediately. It’s strong stuff, so I’ve heard. Anything unusual, then stop, you hear me! Take it in the evenings to begin with — you don’t live alone, do you? You do? Oh, in that case take it in the mornings, just so someone can keep an eye out the first time you take this compound. Can you swallow pills? Swallow them properly, I mean? Because, you know, if one of these things gets stuck in your oesophagus, you could croak! But who knows, maybe it will help you. But I have to go now. You’ve got this.”

It’s easy to imagine that the brave patient who takes these pills despite all of this isn’t very likely to feel a positive effect, even if the biochemical composition of the pills is right. Quite honestly, though, anyone who believes in the nocebo should also believe in its beautiful sister.

I also frequently encourage my patients to say something positive to themselves every now and then. This generally earns me a look that says

“Oh yeah, the shrink’s just saying the same thing shrinks always say”. But if I ask my patients: “How do you think your day will turn out if you stand in front of the mirror in the morning and say, ‘You look like shit, you’re totally brainless and you really don’t deserve to play the game of life. What’s more, today is going to be the shittiest day ever, full of frustrations, mistakes and misfortune.’”?

Most patients burst out laughing at this example, but none of them ever doubts that this gimmick would kickstart a very, very bad day indeed. But if so, if the other side of this particular coin is true, then why shouldn’t positive autosuggestion work too?

We have the right to accept the immaterial gifts of our body and soul. They are good and fine and free and sincere. Also, they’re of no use to anyone else. And don’t forget: hypochondriacs live longer.

[END OF SAMPLE]