In the opinion of the author, the psychiatry/anti-psychiatry rift has had a devastating effect on the lives of people with severe psychiatric problems.

COMMENTARY

Psychiatry used to be a biopsychosocial profession that allowed time to get to know the person, not just treat the symptom. But drastic cuts in the funding of mental health services have dramatically reduced the quality of the service they can provide. Psychiatrists are now forced to follow very large panels of patients. Most of the limited time they are allowed with each is spent discussing symptoms, adjusting the meds, and determining side effects.

Little time is left to forge a healing relationship, provide support, and teach skills through psychotherapy. And patients usually get to a psychiatrist—if at all—as a last resort, only after other things have failed—and with the expectation by the patient and referral source that the main purpose of the visit is just to prescribe medication.

Psychiatrists didn't invent this system, but they have to live within it (except for those whose patients can pay out of pocket for much more personalized care). Most psychiatrists do a good job of diagnosis, prescribing meds, and providing support. Of course, some are incompetent—every profession has its great practitioners, its boobs, and the full spectrum in between.

Results overall for psychiatric treatment are good. The majority of patients improve at rates equal to, or above, those achieved by doctors treating medical illness. But, as in the rest of medicine, a significant minority of patients don't improve at all and a small minority get worse. Treatment failure may be due to the natural course of illness, difficult life circumstances, the patient's behavior, or the psychiatrist's incompetence. Some psychiatrists are not good at diagnosis, use too much medication, and/or fail to establish a good relationship with the patient. And sometimes it may just be a bad match-up of doctor and patient—the nature of their relationship can strongly influence how well the patient does.

Another important factor in treatment failure is that most “psychiatry” is not done by psychiatrists. Primary care doctors prescribe 90% of benzodiazepines; 80% of antidepressants; 60% of stimulants; and 50% of antipsychotics. Some are great at it, but most have too little time and too little training and are too subject to sales pitches from drug salesmen. Psychiatrists are clearly responsible for some of the harm done by excess medication, but the bigger problem by far is rushed primary care doctors, prescribing the wrong meds, to patients who often don't need them. Misleading drug company marketing increases inappropriate prescription by convincing both doctor and patient that there is a pill for every problem.

Psychiatry comes in for a lot of criticism: from within the profession; from other mental health professionals; and from dissatisfied patients. Some of the criticism is fair, some is overblown, and some is just plain wrong.

I, and others within the profession, have criticized psychiatry for its increasing bio-reductionism, decreased humanism, diagnostic exuberance, and excessive dependence on prescribing medication. Psychiatry is far from perfect, but it remains the most patient-centered and humanistic of all medical specialties and has the lowest rate of malpractice among all specialties.

Psychologists criticize psychiatry for its reliance on a medical model, its terminology, its bio-reductionism, and its excessive use of medication. All of these are legitimate concerns, but psychologists often go equally overboard in the exact opposite direction—espousing an extreme psychosocial reductionism that denies any biological causation or any role for medication, even in the treatment of people with severe mental illness. Psychologists tend to treat milder problems, for which a narrow psychosocial approach makes perfect sense and meds are unnecessary. Their error is to generalize from their experience with the almost well to the needs of the really sick.

For people with severe mental illness (e.g., chronic schizophrenia or bipolar disorder), a broad biopsychosocial model is necessary to understand etiology—and medication is usually necessary as...
part of treatment. Biological reductionism and psychosocial reductionism are at perpetual war with
one another and also with simple common sense.
The most important and troubling attacks on psychiatry come from people who feel harmed by it. It
has been surprising to me that my many forceful critiques of psychiatry have met so little criticism
from psychiatrists, while my much less frequent and muted defenses of psychiatry have drawn such
flak from dissatisfied patients. Whenever I twitter or blog anything suggesting that psychiatric
treatment is valuable for some people but not others, I receive a flurry of angry responses declaring
it is totally harmful for everyone.
Satisfied patients are a silent majority—people who have benefited from psychiatry generally have
little motivation to go public with their gratitude. Dissatisfied patients want to be heard—to air their
personal grievances and to protect others from what they see as a dangerous profession.
Their concerns consist of many different variations on two basic themes: they think that psychiatry
makes people worse and that it is “coercive.”
Typically, they have had a disastrous experience with psychiatric medication that was prescribed in
too high a dose and/or for too long and/or in odd combinations and/or for a faulty indication. They
are angry for a perfectly understandable reason—they felt that medications made them feel worse
and going off them made them feel “better.”
Their passion is understandable and their strongly negative view of medication is, in many cases,
appropriate, as far as their personal experience is concerned. But there is no “one size fits all” in
psychiatric treatment. Meds are not all good or all bad. Misapplied they are bad. Prescribed properly
they are good. It is incorrect to generalize from any one person's lived experience to everyone else's
lived experience. Meds that are harmful for someone who didn't need them may be essential for
someone who does.
There is sometimes also the added complaint that psychiatrist or family coerced the patient to take
medicine and/or admitted the patient involuntarily into inpatient or outpatient treatment. Psychiatric
coercion used to be one of the shames of our society. Fifty years ago, more than 600,000 people
were housed in state mental hospital snake pits, often for extended periods with little treatment and
no protection of civil rights.
But times have changed. Coercion is now worse than ever, but it comes from the criminalization of
mental illness and the shameful neglect of the mentally ill. Ninety percent of state hospital beds
have been closed & there are fewer than 35,000 beds left. Beds are so scarce that is now far easier
to be discharged from a psychiatric hospital than to be admitted to one. Hospital stays are measured
in days or weeks, while prison stays are measured in months, years, and decades. The
psychiatry/anti-psychiatry rift has had a devastating effect on the lives of people with severe
psychiatric problems. For them, this is the worst of times and worst of places.
People with psychiatric problems who used to be coerced in state mental hospitals now suffer the
much worse coercion of extended jail time (about 350,000) or homelessness (about 250,000). Fear
of psychiatric coercion is understandable, but now badly misplaced. Many people are still fighting
yesterday's war and are going AWOL on today's war.
The shameful coercion today is the criminalization of mental illness and being forced to live in
dungeons. And it is a different coercion, only slightly less terrible to be forced to live homeless on the
street. More psychiatric care in the community, combined with decent housing, would humanely
protect people from coercion, certainly not promote it.
Psychiatry is far from perfect, but it remains the most patient-centered and humanistic of all medical
specialties and has the lowest rate of malpractice among all specialties.
Dissatisfied patients portray psychiatrists as power hungry bullies trying to control their lives and ply
them with poisons. In contrast, psychiatrists often experience themselves as powerless cogs in an
inadequately funded and disorganized mental health nonsystem, trying to do their best, under very
difficult circumstances, to improve the lot of people suffering from terribly painful symptoms and
terrible life circumstances.
The psychiatry/anti-psychiatry rift has had a devastating effect on the lives of people with severe
psychiatric problems. For them, this is the worst of times and worst of places—the lack of effective
advocacy has many of them shamefully neglected in prison dungeons or living on the street. The
wrong battle lines have been drawn. We should all be fighting together so that our most vulnerable
citizens will have access to a decent place to live and to humane and comprehensive care.
Disclosures:  EDITOR'S NOTE: Readers are invited to comment on our website. Please adhere to our editorial request to leave your full name and professional title at the end of your comment.

Source URL:  http://www.psychiatrictimes.com/blogs/couch-crisis/psychiatry-and-anti-psychiatry

Links: