

The Trouble with Psychiatry

For the last fifteen years, I've practiced psychiatry in a small town north of Boston. It is a solo private practice. I see mostly middle-class patients who come to me with depression, anxiety, substance abuse, and occasionally more severe problems, such as bipolar disorder or schizophrenia.

Like most other psychiatrists of my generation, I have specialized in prescribing medications and have referred patients in need of talk treatment to a psychotherapist. During my training at Massachusetts General Hospital, I was taught that we are on the threshold of understanding the biochemistry of mental illness. After I graduated from residency, I worked hard to keep up with the explosion of neuroscience knowledge, and I absorbed the intricacies of how to use the new psychopharmaceuticals as they poured forth from the drug companies at a dizzying clip. By harnessing these powerful medications, I thought I was providing my patients the best psychiatric treatment possible.

But a couple of years ago, I saw a patient who made me question both my profession and my career.

Carol, in her midthirties, had short brown hair and strikingly green eyes that were filled with despair. Once we were seated in my office, I asked her, "How can I be of help?"

"My father was killed in a car accident," she said, choking back tears.

"How awful—when did this happen?"

"Last month."

Carol told me that she had been in the car with her father, who was driving. They came over a rise in the road, and another car was just pulling out of a driveway in front of them. Her father tried to swerve, but it was too late. They collided with the other car, and her father, who was not wearing a seat belt, was killed instantly. Miraculously, Carol was not seriously injured.

Since then, she said, she had recurrent dreams about the accident, and couldn't prevent herself from replaying the scene during the day. The events would unrel themselves like a movie in front of her, and often she would start sobbing uncontrollably. I recognized these experiences—nightmares and flashbacks—as typical symptoms of post-traumatic stress disorder, or PTSD. I asked her a series of questions about other symptoms, such as poor concentration, insomnia, being easily startled, and the need to avoid situations reminding her of the crash, all of which are commonly associated with PTSD.

She said she was experiencing all of them. Her life was constricting inward. She drove rarely, avoiding especially the road where the accident had occurred.

"Are you avoiding anything else?" I asked.

"I won't watch TV. I can't read the newspaper. I never realized how many stories there are about car accidents in the news."

I asked her about symptoms of depression. She reported insomnia and poor motivation, but no suicidal ideation.

"The worst thing," she said, "is how guilty I feel."

"Why guilty?" I asked.

"It was my fault that we crashed. I got him upset."

Her eyes began to well up. "I was telling him that he shouldn't be drinking."

"He was drinking and driving?"

She nodded. "I told him I could smell it on his breath and that he shouldn't be driving. He got mad, started yelling at me. And then he floored the gas pedal, said something like 'Am I driving good enough now?' That's when it happened!"

I could see that this was more than a simple case of PTSD. She would have complicated feelings about her father to wrestle with—grief, regret, and eventually a good deal of anger.

As the end of the hour approached, I told her a bit about PTSD, about the prognosis for recovery, and about the usual treatments.

"So what do you think I should do?" she asked me.

"I'd like to give you some medication to help you through this," I said. I wrote out prescriptions for the antidepressant Zoloft and for the tranquilizer Klonopin. Then I reached into my file cabinet, and handed her a business card. "And this is a good therapist who I often work with. I recommend that you give her a call and set up an appointment. The medication works better when you are also seeing a counselor."

She looked confused. "Aren't *you* my therapist?"

I shook my head. "Unfortunately, I don't have time in my practice to do therapy. I usually refer patients to psychotherapists whom I trust."

"So . . . am I going to see you again?"

"Yes, we'll schedule another appointment in about a month, to see how the medications are working. But in the meantime, I hope you'll have had a couple of sessions with this other doctor."

Carol still didn't look at all happy with this.

"But aren't there any psychiatrists that do therapy?"

"There are a few," I said, "but not many. They're hard to find these days."

After Carol left my office, I finished writing her intake note. I closed her chart, put my pen down, and looked out my office window at the white-steeped Unitarian church across the street. There was nothing unusual about my encounter with Carol. I did what most psychiatrists do when they encounter a new patient. I sat comfortably in my red leather chair, wearing my suit and tie, and I asked her a series of diagnostic questions. Her answers fit neatly into a recipe book of psychiatric diagnoses called the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, fourth edition), and I pieced together a diagnosis that made sense to me. I then reached over to my desk, wrote out a prescription, and handed it to her.

Pondering this typical appointment, what struck me most was what I did *not* do. I am an MD, having gone through four years of medical school, one year of grueling medical internship in a general hospital, and three years of psychiatric residency at Massachusetts General Hospital. But, like most psychiatrists, I did little to take advantage of those years of training. I did not do a physical exam, nor did I take Carol's pulse or blood pressure. Indeed, the only times I stirred from my chair were to meet her in the waiting room at the beginning and to show her into my secretary's office to make a follow-up appointment at the end.

Just as striking to me as the lack of typical doctorly activities in psychiatry is the dearth of psychotherapy. Most people are under the misconception that an appointment with a psychiatrist will involve counseling, probing questions, and digging into the psychological meanings of one's distress. But the psychiatrist as psychotherapist is an endangered species. In fact, according to the latest data from a group of researchers at Columbia University, only one out of every

ten psychiatrists offers therapy to all their patients.¹ Doing psychotherapy doesn't pay well enough. I can see three or four patients per hour if I focus on medications (such as psychiatrists are called "psychopharmacologists"), but only one patient in that time period if I do therapy. The income differential is a powerful incentive to drop therapy from our repertoire of skills, and psychiatrists have generally followed the money.

So, like most of my patients, Carol saw me for medications, and saw a social worker colleague for therapy. Her symptoms gradually improved, but whether this was due to the medications or the therapy, or simply the passage of time, I cannot say.

Carol's treatment was not particularly dramatic, but her story illustrates both the triumphs and the failures of modern psychiatry. Over the last thirty years, we have constructed a reliable system for diagnosing mental disorders, and we have created medications that work well to treat a range of psychological symptoms. But these very successes have had unpredictable consequences. As psychiatrists have become enthralled with diagnosis and medication, we have given up the essence of our profession—understanding the mind. We have become obsessed with psychopharmacology and its endless process of tinkering with medications, adjusting dosages, and piling on more medications to treat the side effects of the drugs we started with. We have convinced ourselves that we have developed cures for mental illnesses like Carol's, when in fact we know so little about the underlying neurobiology of their causes that our treatments are often a series of trials and errors.

Theories of the neurobiology of PTSD, depression, and the range of other mental illnesses have come and gone over the years, but we are still far away from a true understanding of the biological causes of these diseases. Clearly, thoughts and emotions arise from the activity of neurons, and it makes sense that when emotions are distorted severely, the neurons must in some way be "broken." Theo-

ties about depression over the years have included different versions of the “chemical imbalance” idea. The 2009 version of the American Psychiatric Association’s *Textbook of Psychopharmacology* reviews these candidate chemicals in depth.² Researchers have found evidence of abnormalities in serotonin, norepinephrine, dopamine, cortisol, thyroid, growth hormone, glutamate, and brain-derived neurotrophic factor—yet no specific defect has been identified. Straying outside the world of chemistry, other researchers have tried to find the causes of depression through neuroimaging scans. But this research has been just as inconclusive. Some of the major findings include decreased activity in the left frontal lobe, a shrunken hippocampus, an oversized amygdala, disrupted circuits around the basal ganglia, and miscellaneous abnormalities in the thalamus and the pituitary gland.

The APA textbook authors, utterly unable to tie together these disparate findings, concluded that the “central question of what variables drive the pathophysiology of mood disorders remains unanswered.” You can say that again. The problem is not in the enthusiasm or intelligence of the researchers—but rather in the inherent complexity of the brain itself. A typical brain contains one hundred billion neurons, each of which makes electrical connections, or synapses, with up to ten thousand other neurons. That means a *quadrillion* synapses are active at any given time—the number of people on 150,000 Earths. It is therefore no surprise that we know almost nothing definitive about the pathophysiology of mental illness—the surprise is that we know anything at all.

While the scientific literature contains thousands of papers proposing neurobiological theories to explain PTSD, depression, bipolar disorder, schizophrenia, and other psychiatric disorders, these theories remain unproven, and they are rarely based on an in-depth understanding of how the brain works. Instead, researchers generate these theories by working backward from having discovered that a

certain drug seems to be effective in treating a disease’s symptoms. Thus, the fact that many antidepressants increase levels of serotonin has led to a serotonin-deficiency theory of depression, even though direct evidence of such a deficiency is lacking. By this same logic one could argue that the cause of all pain conditions is a deficiency of opiates, since narcotic pain medications activate opiate receptors in the brain. In fact, pain is caused by a multitude of mechanisms, depending on which organ is involved. Chest pain from a heart attack is not caused by an opiate deficiency, for example, but by a lack of blood flow to certain cardiac tissues, which damages heart cells. This is a true physiological explanation of a disease, one that has guided the development of cardiac medications that act by increasing blood flow to the heart muscle. By contrast, the shocking truth is that psychiatry has yet to develop a convincing explanation for the pathophysiology of any illness at all.

Psychiatry’s scientific failures were encapsulated recently by none other than the country’s chief psychiatrist, Dr. Thomas Insel, the head of the National Institute of Mental Health. In an editorial recently published in one of the top psychiatric journals, Insel summed up the primitive state of psychiatric knowledge this way: “Despite high expectations, neither genomics nor imaging has yet impacted the diagnosis or treatment of the 45 million Americans with serious or moderate mental illness each year.” He added: “While we have seen profound progress in research . . . the gap between the surge in basic biological knowledge and the state of mental health care in this country has not narrowed and may be getting wider.”

The science of psychiatry is riveting, and I have confidence that someday we will understand the neurobiology of emotions, and come up with effective treatments based on that knowledge. But we are much further away from this understanding than most of my patients think. Patients often view psychiatrists as wizards of neu-

rotransmitters, who can choose just the right medication for whatever chemical imbalance is at play. This exaggerated conception of our capabilities has been encouraged by drug companies, by psychiatrists ourselves, and by our patients' understandable hopes for cures.

In medical school, there's an old joke that goes like this: Internists know everything and do nothing, surgeons know nothing and do everything, pathologists know everything and do everything (but a day too late), and psychiatrists know nothing and do nothing. The punch line is particularly insulting to psychiatrists, and it is not really accurate. We know *something* and we do *something*, but we know and we do far less than we might care to admit.

Before his untimely death by suicide at forty-six, David Foster Wallace was considered by many to be the most brilliant novelist of his generation. His 1996 masterpiece, *Infinite Jest*, was a satirical futuristic novel whose plot concerns a movie called *Infinite Jest* that people find so entertaining and alluring that they sit for days watching it, becoming paralyzed and lifeless.⁴ A 1,097-page reflection on the nature of modern entertainment, it became a sensation, winning Wallace a cultlike following, and was eventually included by *Time* magazine in its list of "100 Best English-language Novels from 1923 to 2005."

But Wallace could hardly enjoy his achievements and his fame, because he suffered from chronic depression and anxiety. The history of his treatment has been chronicled recently in both *The New Yorker's* and *Rolling Stone's* magazines, and these accounts give a disquieting glimpse into the limits of modern psychiatry.

Wallace first suffered depression as an undergraduate at Amherst College, and in a story he wrote for Amherst's literary magazine, he provided a vivid picture of his suffering:

You are the sickness yourself. . . . You realize all this . . . when you look at the black hole and it's wearing your face. That's when the Bad Thing just absolutely eats you up, or rather when you just eat yourself up. When you kill yourself. All this business about people committing suicide when they're "severely depressed": we say, "Holy cow, we must do something to stop them from killing themselves!" That's wrong. Because all these people have, you see, by this time already killed themselves, where it really counts. . . . When they "commit suicide," they're just being orderly.

Wallace sought treatment and was prescribed a tricyclic, an older type of medication that was the first effective antidepressant to be developed, but he stopped after two months, later telling a journalist that the medication "made me feel like I was stoned and in hell." Presumably, he was referring to the sedation and other side effects common with tricyclics.

During graduate school at Harvard, Wallace dealt with depression by escaping into alcohol and drug use. Eventually, frightened by escalating thoughts of suicide, he again consulted a psychiatrist, resulting in an eight-day psychiatric admission to McLean Hospital (a hospital where I did a bit of training, since it is affiliated with Mass General). At McLean, according to his mother, "we had a brief, maybe three-minute audience with the psychopharmacologist," and Wallace was prescribed Nardil, another old but quite potent antidepressant, one that requires a special diet devoid of certain cheeses and cured meats.

Nardil worked fairly well for Wallace. Though he still suffered periods of depression and anxiety, he was able to live his life, continue his writing, and get married. In June 2007, however, he ate a meal at an Indian restaurant that caused him days of stomach cramp-

ing, and doctors thought the symptoms might have been caused by an interaction of the food with the drug. Tired of having to worry about the many side effects of Nardil, and having been on the drug for almost two decades, he decided, in cooperation with his psychiatrists, to try to stop it.

Coming off Nardil certainly seemed a reasonable decision. By then, drug companies had produced dozens of newer drugs to treat his symptoms, with far fewer side effects than MAOIs (monoamine oxidase inhibitors, the class of drug to which Nardil belonged). Wallace was tapered off the Nardil and tried on a succession of newer antidepressants. While we don't know the details, from my own experience treating patients with chronic depression I can imagine how his treatment proceeded. His psychiatrist likely rotated through a series of drugs, going from one mechanism of action to another, using combinations of drugs, possibly adding lithium, thyroid, or an antipsychotic to "augment" the effects of other drugs. Nothing worked. Whatever was tried, Wallace remained depressed, and after a year of different drug trials, he was put back on Nardil. But as sometimes happens when a once-effective drug is reintroduced, Nardil had lost its potency. Desperate, Wallace eventually agreed to electric shock therapy, which famously cured the depression of Kitty Dukakis, the wife of the 1988 Democratic presidential nominee, Michael Dukakis.⁷ But it didn't work for Wallace. One night, at the end of August 2008, his wife left him at home alone for a few hours, and when she returned, he had hung himself.

In any field of medicine, patients become desperately ill and die before their time, despite the best efforts of doctors. This is as true in cardiology and oncology as it is in psychiatry. Wallace's story does not imply that psychiatry is ineffective, but his failure to respond to any drug other than Nardil—which was introduced in the 1950s—illustrates a sad truth about our medications. Whether we are talking about depression, schizophrenia, or bipolar disorder, the new drugs

introduced over the past fifty years are no more effective than the original prototypes—such as Haldol for schizophrenia, lithium for bipolar disorder, and Nardil for depression. We are keen to prescribe the newest drugs, and patients assume that much progress has been made in psychopharmacology over the past several decades, but as I'll explore more fully later, this progress has been overblown.

This frustrating reality has recently been demonstrated by several large studies that were not funded by drug companies, and were therefore not biased in their research designs to favor particular drugs. These studies, conducted by the National Institute of Mental Health and known by various acronyms such as the CATTIE trial, the STAR-D trial, and the STEP-BD trial, have demonstrated that the newer drugs for schizophrenia, depression, and bipolar disorder are generally no more effective than the older drugs they have largely replaced.⁸ Furthermore, even our newer drugs' supposed advantage—fewer side effects—is being called into question. For example, the original antipsychotics such as Haldol and Thorazine sometimes caused permanent neurological side effects, which are largely avoided by the newer "atypical" antipsychotics, such as Zyprexa, Risperdal, and Serquel. But research has shown that these newer agents cause problems of their own, such as obesity, diabetes, and cardiovascular disease.⁹

Because of this, the progress of psychiatry over the second half of the twentieth century has been less dramatic than commonly portrayed. We have witnessed a steady accumulation of new drugs, but "new" has not always meant "better." This explosion of products led to the emergence of an entirely new subdiscipline of psychiatry called "psychopharmacology," the specialization in prescribing medications, and psychopharmacologists rarely do therapy. This new discipline ushered in, in therapy's place, the "fifteen-minute med check." Such short visits were unheard of thirty years ago, but have now become the defining appointment of modern practice.

ners. Meanwhile, the psychotherapy skills of many psychiatrists have largely withered away, if they were ever taught to them in the first place.

There was a time when I thought this shift in the profession was a natural evolution. Why put patients through months and years of weekly therapy if simply taking pills worked as well if not better? As it turns out, we were wrong in two ways. We both exaggerated the effectiveness of the new drugs and gave psychotherapy a premature burial.

Linda, a woman in her forties, came to see me a couple of years ago because she had been feeling increasingly discouraged with her life. Her husband was disabled with a cardiac condition and she needed to look after him constantly. Their marriage was filled with conflict, and each day felt like a long argument. Linda wanted to leave her husband, but felt trapped, too guilty to leave him in his time of greatest need.

Her desperation leeched into the rest of her life. Most mornings she woke up both exhausted and anxious. She felt hopeless and regretful of her life decisions. Of greatest concern to me, she had begun to wish she could "just disappear," although she assured me that she had neither the desire nor the "courage" to actually harm herself.

At the end of my customary fifty-minute diagnostic evaluation, I told Linda that I thought she was suffering from major depression, and recommended a medication that might help. I said that I had good experience with Lexapro, an antidepressant in the category of SSRIs (selective serotonin reuptake inhibitors). She wondered why I chose this particular drug, and I explained that Lexapro worked by increasing the amount of serotonin in the brain, and it seemed

to have fewer side effects than other antidepressants. She took the prescription, and I booked a follow-up appointment with her for a month later, which was the soonest I had an opening. I told her that I did not have room in my schedule to see her for psychotherapy sessions, but I gave her the names of two good counselors I knew.

After she left, as I did with my patient Carol, I reflected on several things that I did not tell Linda.

I didn't tell her that, despite my training at Harvard's Massachusetts General Hospital, I have no idea how Lexapro works to relieve depression, nor does any other psychiatrist. Like the Zoloft I had given Carol, while Lexapro increases levels of serotonin in the nerve synapses, there is no direct evidence that depression is a disorder of reduced serotonin. The term "chemical imbalance" is commonly used by laypeople as a shorthand explanation for mental illness. It is a convenient myth because it stigmatizes their condition—if the problem is a chemical imbalance, it is not their fault. Psychiatrists go along with this shorthand, because it gives us something to say when patients ask us questions about pathophysiology. After all, no doctor wants to admit ignorance about the very problems he or she is trained to manage.

I did not tell Linda that psychotherapy might work just as well as medication for her, and that I had decided on medication in part because I received little training in therapy during my three years of psychiatric residency. Like many psychiatrists, I *don't* do psychotherapy because I *can't* do psychotherapy.

I did not ask Linda to have her blood drawn, nor did I send her for a brain scan. Diagnosis in psychiatry proceeds exactly as it did a century ago—by asking a series of questions and analyzing the responses. Patients often ask us for a "diagnostic test." They hear media reports about PET scans, EEGs, and computerized tests of attention. Both psychiatrists and their patients are quick to embrace

these talismans of hard science, but, unfortunately, psychiatric diagnosis continues to lag far behind the rest of medicine. Because of this, the DSM-IV, our diagnostic manual, has taken on the dimensions of a holy book in the field. Every ten years or so, a new edition is published, and the landscape of psychiatry changes. But, as I'll show later, the new diagnoses are based on votes of committees of psychiatrists, rather than neurobiological testing. Because diagnosis in psychiatry is more art than science, the field is vulnerable to "disease mongering," the expansion of disease definitions in order to pump up the market for medication treatment.

Finally, I did not tell Linda that I was often visited by a pharmaceutical representative from Forest Pharmaceuticals, the maker of Lexapro, who would bring me my favorite drink from Starbucks and sandwiches for my receptionist. The rep had told me that Lexapro was the best tolerated of all SSRIs, and while I knew that there is no convincing evidence that this is true, her visit accomplished its objective, which was to plant Lexapro uppermost in my mind. And I, in turn, prescribed it to Linda.

I continued to see Linda for another year or so. She had many side effects on medications, and so I rotated her through different treatments, relying on trial and error because there is little else to guide our prescribing decisions. She felt a little better than when I had first seen her. As often happens in my field, Linda eventually disappeared from my practice. She simply stopped making appointments. I had no reason to believe that she disliked me or was unhappy with my care. But as is common in psychiatry, we had developed no strong therapeutic connection over the course of fifteen-minute visits every other month. Wherever she is, I hope she is doing well.

Like my patient Carol, there was nothing extraordinary about Linda. On the contrary, she is representative of the broad number of patients my colleagues and I see regularly—and she illustrates what

Psychiatrists, who as recently as thirty years ago saw patients for hour-long sessions, often several times per week, have become so tightly scheduled with fifteen-minute so-called sessions that we have little or no time for therapy anymore. Our diagnostic process is shallow and is based on an elaborate checklist of symptoms, leading us sometimes to overdiagnose patients with disorders of questionable validity; or, conversely, to miss the underlying problems in our rush to come up with a discrete diagnostic label that will be reimbursed by the insurance company. We tend to treat all psychological problems the same way—with a pill and a few words of encouragement. Because of this rote approach to treatment, patients are often misdiagnosed and medications are overprescribed. In the end, we misserve our patients, failing to offer them psychotherapies that are sometimes more effective than drugs.

We have been seduced by the constant encouragement from drug companies to prescribe more medications and an insurance reimbursement system that discourages therapy. On top of these inducements, an outmoded training regimen in medical school provides years of unneeded courses in surgery and internal medicine while providing little training in the specific skills needed by psychiatrists.

Pulled by both drug companies and consumer demand to provide immediate drug fixes to life's difficulties, the field of psychiatry has become unhinged, pruned away from its original mission—to discover the causes of mental illness and to treat those causes, not merely the symptoms. At a time when direct-to-consumer drug advertising has tripled in the last ten years, from \$1.3 billion in 1999 to \$4.8 billion in 2008, blockbuster drugs that promise to treat symptoms such as shyness (Paxil), fatigue (Provigil), stage fright (the generic drug pranolol), and sexual problems (Viagra) have become rooted in the public consciousness.¹⁰ Sometimes the drugs work well, and sometimes they do little but cause side effects. Nonetheless, the going narrative is that psychiatry has a biochemical solution for every vari-

ant of distress. This story yields profits for drug companies, prestige for psychiatrists, and reassurance for patients. But the narrative is full of holes.

In *Unhinged*, I will take you on a guided tour of the landscape of modern psychiatry. I will show you what we actually know about the mind—versus what we only pretend to know. I will argue that we psychiatrists spend our days splitting our patients into two: one is a repository of neurotransmitters, and the other is a person with relationships, a job, and aspirations. We treat the neurotransmitters, and we refer the person to somebody else.

The surprise is that our treatments are remarkably helpful to patients, even though we hobble ourselves in this way. Imagine how effective we could be if we embraced all the tools at our disposal. This is my ultimate goal in *Unhinged*—to envision a different kind of psychiatrist, and to provide a road map for achieving this vision.

Chapter 2

On Becoming a Psychiatrist

MY own training began just as psychiatry was in the midst of its transformation from psychotherapy to psychopharmacology. In 1985, three years before the introduction of Prozac, I started medical school at the University of California at San Francisco, with the goal of eventually becoming a psychiatrist. People are often curious, even suspicious, about why psychiatrists choose their profession. I was always interested in the human psyche, and knew that I would become either a psychiatrist or a psychologist. The difference between the two is that psychiatrists go to medical school and can prescribe drugs, whereas psychologists go to graduate school and learn about therapy and research methods, and, with the recent exception of two states,¹ cannot prescribe medication. My father is a psychiatrist, and he advised me to go to medical school—and not only because he wanted to see his son following in his footsteps. He has collaborated with psychologists for years and found that some were frustrated by not being able to prescribe medications. He wanted me to avoid that same potential frustration.

But there was a darker side to my career decision. My mother suffered severe mental illness with delirium.