A CALL TO ACTION

Shrink Wrapped: The Failed Promise of Modern Psychiatry

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The last decade of the twentieth century was a heady time for modern psychiatry. Fluoxetine was released in the in the mid 80's and many other so-called anti-depressants followed on its heels. Though never proven, we touted the neurotransmitter deficit model for depression and truly believed that we were on the threshold of a major breakthrough in psychiatry and neuroscience. In our collective excitement, we dubbed the 1990's "The Decade of the Brain."

Fast forward to present day. Despite widespread and often indiscriminate prescribing, on a per capita basis, there are far more persons off work on disability for anxiety and depressive related disorders than ever before. The increase continues and is exponential.

There are two myths at play that serve to perpetuate the status quo. First, is the myth of *diagnosis* in psychiatry. In other areas of medicine, a diagnosis is a discrete, objectively verifiable condition. There remain many symptom clusters that fail to meet this standard. Lacking objective tests—much less treatments—the rest of medicine classifies these conditions as *syndromes.*

Examples of common syndromes include *Chronic Fatigue Syndrome* and *Irritable Bowel Syndrome*. In a desperate attempt to enhance the prestige of psychiatry—and as a requirement for billing the HMO's in the US—the APA's *Diagnostic and Statistical Manual* incorporates more diagnoses with each edition. The belief that psychiatric diagnoses are defined constructs, on par with other areas of medicine, is the myth at the core of modern psychiatric practice. Simply calling something a *disorder*, does not make it real *(Joel Paris).*

The image of a group of endocrinologists debating whether Type 1 diabetes should be a legitimate diagnosis is laughable, yet this is precisely how psychiatric "diagnoses" are minted. If something is objectively real, we don't debate its existence, and what was truth does not simply become untruth with the next edition of DSM. The DSM committee meetings provide forums for so-called experts to lobby for their pet "diagnoses", ones they feel comfortable treating and ones that will enhance their credibility and prestige.

Further, if these diagnoses were real and credible, then why do psychiatrists so commonly disagree among themselves? It is common to hear reference made to a psychiatrist's particular "style." One psychiatrist's Borderline Personality Disorder is another's Bipolar Type 2, with entirely different treatment protocols.
Lacking consensus on diagnosis, it is no surprise that the trajectory of psychiatric patient care is highly variable, depending on the bias of the treating psychiatrist. Highly variable production systems operate at the expense of quality. And who bears the cost of a highly variable system of care? Certainly not the treating physician. Most physicians are paid for face time, not for outcome. This is akin to a contractor coming to your home and being paid for simply showing up.

If strike one—so to speak—is that our diagnoses are syndromes, then strike two is that our medical treatments lack efficacy. Given that we truly have no idea *what* we are treating in the first place, this should not come as a surprise! An embarrassing and rarely mentioned statistic, is that our so-called *anti*depressants barely separate from placebo. Further, we've since learned that many negative studies were simply mothballed *(Lancet, 2012).*

What is truly incredible is that these medicines are still being marketed as *anti* anything. If our antidepressants and antipsychotics lived up to their lofty promise, most psychiatrists would be out of work and the "treatment resistant" patients clogging our inpatient and tertiary care units would be promptly discharged. This, of course, is not the case.

Unfortunately, the public continues to drink from the punch bowl still being served by mainstream psychiatry. How many times have you heard a friend recounting a visit to the doctor?

"The doctor says I have a brain disease called Major Depressive Disorder. There is not enough serotonin in my brain, apparently. He started me on Cipralex."

Two months later you ask how she's doing.

"Oh that medication didn't work very well, I'm still off work. My doctor added a second medication, Wellbutrin to 'boost' the first one, plus I'm on something to help me sleep…insomnia is a side effect of Wellbutrin."

Two months later your friend stops by for a visit.

"My doctor thinks the reason my medications aren't working is that I might have Bipolar Disorder. He says there's a 'soft' type that's increasingly diagnosed these days. He added a mood stabilizer. I'm on four meds now and still off work. I'm starting to lose hope."

The above is played out countless times, day in and day out. As a boomer psychiatrist, trained in the era of "biological psychiatry," I soon realized that we were not healing patients in any substantive way with our medications. We are creating life-long mental health care *consumers.*

We prescribe mediocre treatments for phantom conditions. We cling desperately to the cloak of expertise and knowingness. We have become less interested in the complex personal stories that might explain a patient's suffering and inform non-pharmaceutical approaches. We are quick to identify "disorder", when the patient's challenge might be a natural and logical downstream manifestation of upstream and primary causes. This, to be fair, is a criticism that applies to other areas of medicine.

The conventional medical paradigm is rooted in the principle of specificity—a specific treatment for each discrete *disease.* In common parlance, *a pill for every ill.* We are in an era of increasingly specialized medicine, where the physician puts his or her organ of choice on

a pedestal, often treating the downstream symptoms as the primary condition. When this fails—as it commonly does—psychiatrists often resort to desperate and toxic poly-pharmacy.

Such prescribing is often the result of *therapeutic despair* on the part of the treating physician. When a patient does not respond to treatment—and with physician's ego on the chopping block—the doctor is desperate to *do something*, anything. It seems that uninformed action is deemed somehow better than inaction.

This demonstrates an all too familiar behavioural pattern and one not unique to the trades: *when the only tool one has is a hammer, everything looks like a nail*. The hammer in this case is the prescription pad. After many failed medication trials, the treating psychiatrist concludes that the problem lies with the patient, who is deemed *treatment resistant.* The blame for treatment failure is projected onto the patient—*they* are treatment resistant.

What of the possibility that we are simply using the wrong treatments? Am we missing something? Rarely are these questions at the table. Curiosity and humility are simply thrown under the bus. Above all, do no harm? Also under the bus. Despite all the claims for evidence-based and patient-centred care, the unavoidable and tragic conclusion is that the status quo works very well for the *industry of care.* For the patients? Not so much.

Much of what we do in clinical practice is simply "chasing smoke." We view the downstream symptoms as the primary condition. Any first year medical student understands that fever is not a disease or disorder, it is a sign that there is something else amiss, something quite remote from the fever itself. In medicine—and particularly in psychiatry—we often chase smoke.

The majority of those labeled as *depressed*, are in fact *distressed* by the events in their lives and the stories they tell themselves about who they are. Predictably, they fail to respond to our pharmacopeia. Lost in the rush to increasingly specialized medicine, is the appreciation for the human organism as a whole. We are the sum of our complex and interfacing systems, where symptoms in any one area might be secondary to remote *upstream* mediators. The overarching clinical question then becomes, "Is this symptom the chicken or the egg?"

In our search for a better paradigm we might look to the wisdom of our ancient ancestors, from the Greeks, traditional Chinese, and yogi masters from thousands of years ago in India. These teachings share the view that there is far more to us than meets the eye. Am I my thoughts? Is it as simple as, "I think, therefore I am?" Who am I, really? This question reflects our timeless quest for connection, identity, meaning and purpose.

Connection with ourselves and with the world around us forms the bedrock of *spritual health.* This new spirituality transcends specific religious affiliation and has spawned the phrase "spiritual but not religious." A holistic paradigm recognizes the importance of connectedness and is central to the Constitution of the WHO, wherein: "Health is a state of complete, physical, mental and social well-being and not merely the absence of disease or

infirmity." Social well-being flows from a sense that we are connected with ourselves and with the world around us.

The truth is, we were never evolved to live as we are. We evolved to live in clans, with myriad connections to others, with each member having a purpose that supported the whole. The price we've paid for the modern *lifestyle,* with all its conveniences and trappings of *success*, is profound disconnection. There is a pandemic of distress and existential despair. The boomers have chased happiness for decades. Yet here we are. Bigger cars, monster homes, extravagant vacations, on line shopping, cosmetic surgery… something, anything to *make* us happy.

When our happiness remains elusive, we go to our doctor. We are then given a simple checklist that confirms we *are depressed*. Never mind that we really have no idea what depression *is* and its interface with normalcy. Recognizing this dilemma, the ancient Greeks created a boundary between *angst* and *melancholia*. Angst was a response to some life challenge and was inherent to normal human experience. Melancholia was a distinct, profound and continuous depressive state that seemed independent of life circumstance.

Until the 1980's, a patient's depressive complaints were classified as being either *reactive* or *endogenous*. This parallels the ancient boundary between angst and melancholia. Reactive depressive symptoms were much less likely to respond to medication and were referred for psychotherapy. This important distinction was dropped from DSM 3 *(1980*). We are entering the fifth decade of an ever-expanded and over-inclusive concept of mental disorders. That this coincides with the introduction and aggressive marketing of novel "anti" depressants, is no coincidence. We are in an era of medicalising *distress,* where most patients prescribed medications will fail to benefit *(BMJ, 2013)*. They will instead, exhaust themselves going down rabbit holes that are proven and guaranteed to fail.

Elements of a holistic model

We tend to see only what we are trained to see or are comfortable managing. The decade of the brain has got us no closer to curing mental illness. Over the past decade there has been a dramatic decrease in the release of new psychotropic medications. It seems that even the pharmaceutical industry is throwing in the towel. Tweaking brain receptors, split of from the organism as a whole, is simply barking up the wrong tree. There is a better way.

The body:

The benefit of movement and exercise for our mental and physical well-being is widely recognized. We're all familiar with the saying, "healthy body—healthy mind." A truly healthy body goes beyond the facade of one's appearance or BMI. Vital health is from the inside out. Central to this, is the mind-gut connection. While the serotonin produced in the gut does not cross the blood-brain barrier, inflammatory cytokines certainly do, where they severely compromise serotonin turnover. What triggers this inflammatory process? We

need look no further than the modern first-World lifestyle. The standard American diet (SAD diet) is inflammatory. The stress response is inflammatory.

Food as medicine is not a new concept. Hippocrates, considered by many to be the father of modern medicine, implored his patients: "Let food be thy medicine and medicine thy food." Beyond passing familiarity with our national food guides, which are obsolete even as revised versions are published, today's doctors get little or no training in nutritional health.

How many psychiatrists do a food diary with their patients? How many are aware that inflammation might be a significant perpetuating factor for a patient's depressive symptoms, much less test for it? How many are able to prescribe a specific nutrition plan that would support recovery and vital health? Beyond being passive recipients of *care*, how many psychiatrists call on their patients to be active partners in their holistic recovery plan? My patients are consistently amazed that a psychiatrist is asking them what they eat and at being sent on their way with a lab requisition and a nutrition remediation plan.

The mind

If our brains can be compromised by processes external to the blood-brain barrier, is the reverse also true? How do our thoughts and emotions impact our bodies? Living in the first world, we are often in a state of heightened sympathetic tone—a state of fight, flight, or freeze. This adaptation is deeply wired into our brains and served us well for most of our evolutionary history, where imminent threats to life or limb were not uncommon. The threat would present itself, but once the threat was over—and if we survived—our nervous system would return to the restful state required for the body to heal and repair.

Fast forward to present day. The threat is no longer the discrete and tangible tiger or rival tribesman. Today's threat comes from having the luxury to sit and think, or more accurately ruminate, about all the potential calamities that might come our way. There is no such thing as *stress,* there is only the stress *response* to an external challenge. Life is challenging, it does not have to be stressful—stress is a *possibility*.

Stress is a reflexive protective *response* at the level of our limbic brain—more specifically, the amygdala. In the absence of an objective threat to life or limb, the stress response is commonly triggered by *the stories* we tell ourselves—the so-called *amygdala hijack (Goleman,1996)*. While we might not completely eliminate the amygdala hijack, we can certainly influence what happens next. Rather than simply being along for the ride, we can learn to pause, witness and reflect: *Am I using my brain, or is my brain using me (Tanzi & Chopra)?* We can redirect from thoughts that are not serving us, recognizing that there is no such thing as stress in the external world, there is only the stress we *create* in response to life's daily challenges.

The stress response depletes the body in so many ways. As is the case with the SAD diet, stress is inflammatory. Chronic inflammation is an essential component of chronic diseases *(Liu et al, 2017).* Beyond its potential negative impact on mood, high levels of inflammation are commonly seen with PTSD, along with a host of medical conditions

including coronary heart disease, diabetes, cancer and dementia. Stress compromises our immune response and in combination with our nutrient poor SAD diets, heightens our susceptibility to disease. Even when not afflicted by a diagnosable illness, we feel depleted, lacking vital health.

A common presenting complaint is the patient claiming to *have* anxiety, or beyond that, an anxiety *disorder*. Generalized Anxiety *Disorder* is the *diagnosis* commonly applied. Rather than invoking yet another *disorder*, we might explore whether the anxiety *response* is a natural and logical consequence of dwelling on contexts beyond our immediate control. We don't classify tennis elbow as a disease. Tennis elbow is an overuse injury. Anxiety could be reframed as an overuse injury—overuse of the mind.

If I have my hand on a hot element, I can take Tylenol for the pain, or I can take my hand off the element. If I *have* anxiety, I can take Lorazepam, or I can learn Mindfulness Based Stress Reduction. I can learn to meditate. I can evolve, giving up patterns that no longer serve me. I can take my power back, redirecting from worrying about outcomes I cannot directly control. I can learn to quiet the mind, to think only when it serves me. I can experience the healing that comes from *alert thoughtlessness* (Eckhart Tolle).

The spirit:

Spirit—herein defined as connection—is identifying with something beyond the material world, the world of form of *form (Deepak Chopra)*. This connection has two poles—connection within (the *intra*personal) and without (the *inter*personal). We tend to be distracted by the noise around us, the external relationships. We feel hurt or rebuffed when we perceive some narcissistic injury. Brooding about about how others treat us, we fail to recognize that we are our own harshest critics. We've incorporated so many messages, subtle and explicit. We can't even remember where the story came from, yet we keep telling it:

"I am not enough."
"I am a failure."
"If others really knew me, they wouldn't like me."
"I feel so guilty for my mistakes."
"I hate myself."

How is healing possible in such a toxic intrapersonal space? It is not. Without self-compassion, nothing else can take hold and flourish. Not CBT, not the next antidepressant trial, not even the whole foods organic diet. After almost three decades of psychiatric practice, I continue to be amazed by the prevalence of self-loathing. In clinical practice, this is often the elephant in the room, akin to "Don't ask, don't tell." The patient is certainly not going to volunteer, "By the way doctor, I think you ought to know that I really hate myself." Conversely, the psychiatrist is unlikely to ask, "How do you feel about yourself." Lacking their own self-awareness, the psychiatrist would be very uncomfortable knowing how to respond in any helpful way to a patient's intrapersonal despair.

Fundamentally, most of us have no idea who we are. How can we have compassion for something we don't know? Self-awareness is the foundation for self-compassion. Our sense of self is highly conditioned. We identify with our roles, relationships, successes and failures. "I am a psychiatrist." No, I am not that. Psychiatrist is a temporary role I play in the movie of *My Life.* Who am I when I am not in that role? Whatever handle we identify with, does it capture the essence of who we are, or is it something that can change? If "I am a success," then who am I when I fail?

We have become so identified with the *doing,* that we've lost awareness of the *being* that is at our essence. On the day of our birth we cannot avoid awareness of being. There is no inner dialogue or *story* telling us who we are, or where we might me going. Undistracted by the thought stream, we are immersed in the silent witnessing that is our essential nature. This silent witnessing is central to the practice of meditation. From the stillness of *no mind,* we are content and whole. We are freed from the insatiable quest for something to *make* us happy.

Putting it all together

Radical change requires radical action. Radical action is far-reaching and thorough—no stone is left unturned. Our treatments fail not because our patients are treatment resistant. Our treatments fail because they are not sufficiently radical. We are a complex interface of biological, psychological, social, and spiritual components. A radical intervention dictates treating all the components of health assertively and simultaneously. In this context, a model reliant on simple symptom checklists as evidence for *any* primary *disorder*, is doomed to fail. How could it be otherwise?