Doing Psychiatry WRONG

A Critical and Prescriptive Look at a Faltering Profession

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CHAPTER 1
Seeing Through the Illusion of Biological Psychiatry

Between 1994 and 2004, I evaluated more than 3,000 psychiatric patients in the emergency room at three hospitals in Baltimore. Some of the patients I saw had unusually challenging problems, and their stories set me to writing a series of articles for *Psychiatric Times*, which I later collected and published as a book, *Psych ER: Psychiatric Patients Come to the Emergency Room*.[1]

Halfway through my decade in the ER, I began to see that many of my patients were telling stories about their present and past lives that did not square with the diagnoses they had been given.[2] Eventually, I realized that most of those judged to have bipolar disorder and schizophrenia—to cite just the most egregious mistakes—never did meet the criteria set by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.

Listening to my patients' stories, it became clear to me what had happened: symptoms they reported were matched by a clinician to the *DSM* criteria for bipolar disorder and schizophrenia without the *meaning* of the symptoms ever being ascertained—all but assuring a wrong diagnosis. While working in a community mental health center and for a private practice group, I observed a similar mismatch between patients' stories and their diagnoses. Gradually, I had to acknowledge that, in psychiatry, misdiagnosing patients had become the de facto standard of care.

Convinced that they had a "brain disease," many of my misdiagnosed patients took prescribed psychotropic medication that was not needed, sometimes to their detriment. Most of these patients had personality disorders, used illicit drugs, or consistently made the kinds of choices that

inevitably lead to erratic emotional states that produce psychiatric symptoms, especially "mood swings." I was left to wonder how physicians could have violated their responsibility to see and hear their patients correctly, and ignored Hippocrates's injunction, "First, do no harm."

Most psychiatrists are trained now to believe that human thinking, feeling, and behavior, whether normal or abnormal, have their primary origin in the workings of the brain's neural substrate. Patients who have symptoms that meet the criteria for a mental disorder will most likely be told they have some kind of "chemical imbalance" and need one or more drugs to correct the imbalance. The implication here is that they have disordered and pathological lives because they have a malfunctioning brain.

There is good empirical evidence that correctly diagnosed bipolar I disorder and schizophrenia involve a glitch in brain structure and function, though no specific cause for either illness has been established. As much as any other factor, the current crisis in psychiatric diagnosis derives from a leap that was made from the near certainty that some mental illnesses are brain disorders to the unjustified conclusion that *all* mental illness is biologically driven. If a symptom is merely the behavioral manifestation of a biological malfunction, the idea that symptoms need to be understood in the context of the patient's life—that is, that abnormal emotion and behavior point back to something the patient is doing wrong and needs to modify—becomes tenuous indeed. If biology is the primary determinant of human experience, then psychoanalytic, psychodynamic, developmental, cognitive, and existential approaches to understanding behavior are of secondary importance. Many psychiatric residency programs no longer teach these theories of the self, or include them only marginally. Responding to this gap in their training, residents in some programs have lobbied vociferously for the return to the curriculum of the dynamic and humanistic approaches to understanding psychopathology.

If behavior has no specific meaning, it can have any meaning. For a variety of reasons, psychiatrists appear to be invested now in assigning the "worst" diagnoses to patients whose behavior is erratic, bizarre, and threatening, and who are difficult to treat with psychotherapy. For some time, the figure cited for the prevalence of both bipolar disorder and schizophrenia was about 1%. After the atypical antipsychotics and the newer anticonvulsant mood stabilizers came on the market and were declared to be user-friendly, the diagnostic net was cast farther out, and those numbers rose dramatically. Surely, a self-serving bias came into play here: by calling a patient bipolar or schizophrenic, the clinician opened the way for the patient to *become an illness* that needed to be "cured" with medication, and justified downplaying or ignoring altogether the

complex dynamic needs of those who would require long-term, demanding psychotherapy. Misdiagnosing a patient could make life easier for the diagnostician, but at the cost of burying the truth about the patient's life, sometimes forever.

Most wrong psychiatric diagnoses tend to stick with patients. Clinicians are reluctant to risk what they see as the possible adverse clinical or legal consequences of changing their original call, or a call made by another clinician. A particularly cruel consequence of misdiagnosing someone with schizophrenia is that the medication prescribed to quell misread "psychotic" symptoms can itself cause a *tardive psychosis*, so named because it takes time to develop.[3] This is thought to be caused by an overproduction of postsynaptic dopamine receptors in compensation for the drug's blockade of the overactive presynaptic receptors, the explanation posited for the original psychosis. Those who go off antipsychotic medication suddenly are prone to a "discontinuation syndrome," where psychotic symptoms can occur, even if the patient did not have them initially.

If a patient is misdiagnosed with and treated for cancer, a lawsuit is almost sure to follow. Yet most psychiatric misdiagnosis goes unchallenged by the victims and the courts—an irony, considering that psychiatry is increasingly thought of as a medical discipline. This happens because there is no standard a clinician is held to in justifying the diagnosis of a mental disorder. Physicians diagnosing cancer must have radiological and pathological evidence of a malignant process. Unless a patient's change in mental status is due to a physiological cause that can be substantiated by laboratory tests—as would be the case with an electrolyte, endocrine, or metabolic derangement, or with drug toxicity—the psychiatrist making a diagnosis must depend on observations of and reports by the patient, and on information volunteered by others. After many years of clinical work, it is clear to me that patients' reports of abnormal thoughts, feelings, and behavior can be "stretched" to make the diagnosis of any number of mental disorders, simply by matching their symptoms to one or another checklist in the *DSM*.

Reports of symptoms by patients are often vague and are usually taken by clinicians at face value. Few psychiatrists now have any interest in identifying the possible ways that abnormal thinking, feeling, and behavior could be due to the inauthentic and self-destructive choices a patient is making, or in looking into how unacknowledged (and sometimes unconscious) choices made long ago continue to influence a life. This is what it would be to uncover what the patient's symptoms *mean*. Instead, "meaningless" symptoms are targeted with mood stabilizers, antipsychotics, and atypical antipsychotics. I once heard a representative from a leading drug company try to convince his audience that his product was the drug to use when, as

he put it, “there is psychosis in the diagnosis.” Not long after that I heard a psychiatrist at a grand rounds conference say, with obvious pride, that he had a “low threshold for diagnosing psychosis.” With psychiatrists and drug companies thinking in this way, the odds that patients will have their stories heard correctly are diminished.

Intuitively, one would expect that the reports of toxic cardiac and metabolic effects sometimes seen in patients taking mood stabilizing and antipsychotic drugs would have encouraged psychiatrists to be more careful about diagnosing mood disorders and psychotic disorders, but this has not been the case.[4] Instead, as more prescriptions are written every day, drug companies and clinicians who write journal articles about these drugs recommend that patients be informed of the potential risks, have periodic electrocardiograms, and be monitored for weight gain, as well as for elevation of blood glucose and triglycerides.

Usually, patients implicitly accept their psychiatric diagnosis. They are often relieved and reassured to hear that the emotional pain they are suffering is not due to any fault of their own. We live in a culture where people believe they are owed a drug for every problem, and if one is not available it soon will be. In an age of growing secularism, disguised as it is with the many faces of a false spiritualism, a pill on the tongue replaces the communion wafer as a conduit to transcendence, courtesy of neuroscience and psychopharmacology.

Where psychoanalysis once maintained that the unconscious mind ruled behavior and that only the psychoanalyst had the key to unlock its paralyzing secrets through dream analysis and free association, biological psychiatry now insists that a “chemical imbalance” in the brain causes mental illness and that only a medical doctor can write a prescription to fix the problem. Freud felt that psychoanalysis could at best transform neurotic misery into everyday unhappiness. Peter Kramer did Freud one better when he claimed in *Listening to Prozac* that some of his patients on Prozac felt “better than well.”[5] If, by taking a pill, patients can get around having to find out why they feel depressed, many will choose to do just that. Most psychiatrists see this pharmacological solution as an acceptable way of handling the problem.

Our inclination toward self-deception—the lie we tell ourselves, which is usually called “being in denial”—is rooted in our need to continuously respond to a world that often does not offer us what we want and need.[6] Self-deception allows us to believe what we otherwise could not believe, so we can get what we otherwise would not have, or at least have so readily. What the French existential philosopher Gabriel Marcel said about betrayal being “pressed upon us by the very shape of our world” is true as well for self-deception.[7] We deceive ourselves about things large and small because everyone and every situation we encounter requests—and at times

requires—us to do so. As a result, most people are self-deceived most of the time. We go along to get along.

Patients tend to accept the promise of biological psychiatry because it gets them off the hook as creators of their own problems, while offering a solution that does not require them to change their lives. Managed care companies and health maintenance organizations (HMOs) embrace this paradigm because treating symptoms with a pill is cheaper than paying for extended psychotherapy or psychiatric hospitalization. The drug companies are happy because they are getting rich by selling more drugs to more people all the time. And psychiatrists are becoming accustomed to the idea of prescribing pills to treat symptoms (without having to worry about what these symptoms mean) because this is the only way they can earn a living now. Their compensation from third-party payers for a 50-minute therapy hour is paltry, but turning out three medication checks an hour pays pretty well. Psychiatrists who work on inpatient units in psychiatric hospitals are also forced to prescribe medication if they expect to be reimbursed by these same third-party payers.

The notion that we believe what we want to believe has been around for a long time. Fooling ourselves can reach the level of *illusion*—a condition of being deceived by a false perception—if that perception figures prominently in what we believe and in how we live. As it is most strictly conceived and practiced, biological psychiatry has slowly but surely become not only an illusion but a *collective illusion*, being subscribed to by so many—patients, doctors, drug makers, insurers—whose needs it meets, if inauthentically. The pie-in-the-sky promises perpetrated through this illusion stretch to the horizon: just spend enough money and do enough research and every mental illness will be understood. There is something for everybody here, which is why the illusion persists.

"Every age has its peculiar folly; some scheme, project or phantasy into which it lunges, spurred on by the love of gain, the necessity of excitement, or the mere force of imitation." So noted Charles Mackay in *Extraordinary Popular Delusions & the Madness of Crowds,* published in England in 1841.[8] Already, in mid-nineteenth-century Europe, Mackay had plenty of examples of self-deception that rose to the level of a collective illusion, scams and follies that gripped large numbers of people and, sometimes, whole nations: the tulip mania in Holland, alchemy, the Great Crusades, and the witch burnings are just a few of those he cited. Every age is susceptible to its unique version of self-deceiving folly. Starting in the mid-twentieth century, one of ours was the outsize role attributed to the brain by psychiatry and society in determining all we think, feel, and do.

Psychiatry has always been viewed with some suspicion. One hears it said, sometimes in jest, sometimes seriously, that psychiatrists are more

abnormal than the patients they treat (no one claims that cardiologists have worse hearts than their patients or that surgeons are themselves in need of surgery). Hollywood has often portrayed psychiatrists as betraying their patients, while simultaneously destroying themselves. Perhaps these filmmakers, and the writers who create the stories behind their films, are the ultimate seers into the human condition. Freud himself acknowledged, "Imaginative writers are valuable colleagues. In the knowledge of the human heart they are far ahead of us common folk."[9] Maybe these creative people knew all along that psychiatry never really did get it right, or serve its patients well, not when psychoanalysis was in vogue and certainly not now that biological psychiatry runs the show.[10]

The affront to psychiatry caused by the insistence that all mental illness derives from a brain chemical imbalance occurred simultaneously with a general decline in Western culture. People used to talk about "selling out," which meant giving up what they really believed in, usually for the promise of fame or money. Selling out once implied a lower level of personal integrity and satisfaction. These days, that lower level is unabashedly courted by most people from the start, and no one feels the less for beginning at that level, or staying there. The closest anyone comes now to acknowledging an ultimate good in the workplace is what the business world likes to call "creating value for shareholders." This is the program the drug companies follow as they continue to help define and bankroll biological psychiatry. What a fine way to say that greed is the only good, as the Michael Douglas character Gordon Gecko does in the iconic 1987 film *Wall Street*. In this new ethical dispensation, Gecko may make our skin crawl, but there is no contravening ethos strong enough to convince us that he is wrong, either.

It is no surprise that, in the absence of any other value, money filled the vacuum as the default value and became the ultimate desideratum. Many psychiatrists now are acquiescing to billable hours and the bottom line as the primary objectives of their work. I have colleagues who, at the end of the day, wonder if any goal other than survival is even worth considering. Freud understood that those under attack often identify with the aggressor as a strategy for dealing with their anxiety and surviving the onslaught. Simply put, psychiatrists have surrendered to market forces. Gratification delayed during years of medical and specialty training calls out to be slaked, school tuition and the mortgage need to be paid, and a dignified retirement must be secured.

A psychiatrist friend, who has spent his entire career on the staff of one of the country's premier psychiatric hospitals and is about to retire, told me with a hint of smugness that he made $200,000 during the previous year. Then he told me, without any detectable regret, that he was seeing over 400 patients a month. This is a clinician who started his

career doing therapy with patients, then, under pressure, turned to doing three medication checks an hour. Some psychiatrists I know have started referring to themselves as neuropsychiatrists or psychopharmacologists to emphasize their allegiance to the currently fashionable—and profitable—quick fix. Others left the profession in disgust and despair.

As a clinician who writes about patients, I am imbued with what Albert Camus saw as the writer's responsibility to be a *witness* to the injustices of his time.[11] Staying silent after seeing people harmed by the ultimate "helping profession" would be to tacitly accept this dark irony. For the better part of a decade, though I was sometimes critical of how so many of the patients I worked with in the ER had been misdiagnosed and wrongly medicated, I did not directly question the integrity of the profession itself. The articles and the book, *Psych ER*, that I wrote based on this experience came mostly from inside the box. But then I gradually came to see that much of what made up psychiatry's "box" had indeed become toxic. From that point on, to be true to my patients and to myself, I would have to think, practice, and write somewhat outside the box.

CHAPTER 2

How Biological Psychiatry Lost the Mind and Went Brain Dead

In 1980, the American Psychiatric Association put out a new edition of the *Diagnostic and Statistical Manual of Mental Disorders*, its third. Spearheaded and edited by Robert L. Spitzer, the goal of the *DSM-III* was to create an "objective" psychiatry. This was to be a new paradigm that would set psychiatry on a firm scientific foundation.[1] In deliberately objectifying symptoms by ignoring their meaning, the plan was to save psychiatry from the "soft," subjective method of psychoanalysis that had informed the first two editions of the *DSM*. With this "hard," objective, and scientific stance, it was anticipated that psychiatry would become more like the other medical specialties.

The problem with this objective approach was that real life is *subjective* to the core. It is just this "soft," messy stuff in human experience that has to be acknowledged and assessed if the abnormal behavior that is labeled as a mental disorder can be understood and clinically challenged. When symptoms of unspecified meaning are used to make a diagnosis—*when the behavior itself is taken to be the illness, without regard for the part that behavior plays in the totality of the patient's life*—this subjective experience gets frozen out. Resorting to yet another metaphor, the essence of what is required to make a valid diagnosis lands on the cutting-room floor.

In *Brave New Brain*, Nancy C. Andreasen seemed pleased when she noted, "Since the development of the *DSM III* the entire process of defining mental illnesses and making diagnoses has become both objective and public."[2] To be objective in this way requires that pathological experience

and behavior be reduced to symptoms that are taken at face value, without regard for the context or meaning of the behavior being assessed. Objectivity somehow became conflated with validity here, as psychiatry moved closer to medicine.

Even in somatic medicine, whose standards psychiatry hoped to adopt, symptoms are not always objective. No one who has witnessed repeated chest-pain-rule-out-MI evaluations in the emergency room would maintain that patients who come in with this kind of pain are having objective symptoms. Ultimately, the ER attending must determine what the pain reported by the patient signifies. Does it originate in the musculature of the chest, or in the skeleton, or does it come from under the sternum? Is it anginal, the result of restricted blood flow in the coronary arteries? Or worse, is it due to cell death in cardiac muscle caused by a shut-down of that flow?

An electrocardiogram and cardiac enzyme levels may or may not be helpful in establishing the meaning of the pain reported by the patient. Even when there is a physiological cause, symptoms can be subjective because they are being experienced and described by a person who is subjective. Finding the origin and the meaning of a patient's symptoms, and then making a valid diagnosis, involves the art of medicine as well as the practice of medical science.[3]

Delirium is known to have over 100 antecedents. Electrolyte and endocrine imbalances, as well as the ingestion of a number of toxic substances, are just a few of the conditions that can disrupt normal brain function to produce alterations in mental status. It is generally agreed that because of the medical illness exclusion criteria that were initiated with the *DSM-III* and continued in subsequent editions, the diagnosis of mental disorders due to medical and physiological conditions has been greatly improved. Many patients who present with psychiatric symptoms caused by these conditions are now being spared a wrong diagnosis of a primary mood disorder or a schizophrenia spectrum disorder. Several years before the publication of the *DSM-III* in1980, one of my friends, then in his mid-30s, was hospitalized for alcohol dependence and depression. In spite of having had the classic symptoms of alcoholic hallucinosis and no prior psychotic experiences, he was diagnosed with schizophrenia! It is less likely that this mistake would be made today.

If a clinician can tie a psychiatric symptom to a medical or physiological condition, the origin and meaning of that symptom are established. It is with primary mood disorders and schizophrenia spectrum disorders that do not have an obvious medical or physiological component that the *DSM*'s disregard for the meaning of symptoms has led to so much wrong diagnosis.[4,5]

In *Brave New Brain*, Andreasen acknowledged the limitations of diagnosing patients using objective, behavioral criteria, even as her enthusiasm for doing so was obvious. What she says here about schizophrenia is true also of bipolar disorder.

> When *DSM III* was written, however, concerns about overdiagnosis of schizophrenia and poor reliability led to an emphasis on symptoms that were easily defined because they were more objective than subjective. Specifically, the definition emphasized hallucinations (hearing voices) and delusions (a variety of false beliefs, such as being controlled by outside forces or persecuted). The definition of schizophrenia became more reliable with the new *DSM III* criteria, but the essence of its concept may have been lost in the process.[6]

Here is an acknowledgment that, in the *DSM-III* and its later revisions, subjectivity has yielded to objectivity and that validity (accurately naming a patient's pathological experience) has taken second place to reliability (allowing multiple clinicians to come up with the same diagnosis, right or wrong). Many clinicians now feel that as long as the makers of the *DSM* insist on trying to give us an objective psychiatry and continue to ignore the subjectivity that is the essence of both "normal" and pathological thinking, feeling, and behavior, we will persist in laboring under a classification and diagnostic system that often misses the point, and ultimately the patient.[7,8]

Though the *DSM-IV* is a compendium of mental disorders, nowhere in this volume that is thick with lists of psychiatric symptoms is the concept of mind ever defined. Nor is there any discussion of the role played by the mind in generating and sustaining mental disorders. In a section titled "Definition of a Mental Disorder," the following explanation is given for the dilemma faced by clinicians as they try to diagnose a mental disorder without a concept of mind.

> [T]he term *mental disorder* unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute.[9]

This same nondefinition of a mental disorder appeared earlier, in exactly the same words, in both the *DSM-III* (1980) and the *DSM-III-R* (1987), and later in the *DSM-IV-TR* (2000). With all the progress psychiatry claims to

have made in understanding and treating mental illness, the makers of the *DSM-IV* seem to be conceding that, in the two decades between 1980 and 2000, no progress was made in deciding what a mental disorder is, or, for that matter, what the mind is. I would offer this rudimentary definition: *the mind is the constituting power of consciousness, an active, ongoing, purposeful operation that involves free will, meaning, and choice, which is dependent for its functioning on an active, reciprocal brain substrate.*

That the lack of a concept of mind might impede psychiatry's efforts to parse the varieties of mental illness is not acknowledged in the *DSM-IV.* This omission signals that the mind, once considered to be the seat of all we think, feel, and do, is no longer seen in that way. In fact, a good deal of knowledge about the mind that psychiatry accumulated during the century before biological psychiatry became the dominant paradigm is given short shrift here. The *DSM-IV*'s silence on the role played by the mind in mental illness created a vacuum that was gradually filled by the empirical findings of a fast-developing brain science, though this result was not the intention of the authors of the *DSM-III.*

This next quote from the *DSM-IV* can be taken as further evidence that objective psychiatry tends to emphasize mental illness as an entity in itself at the expense of considering what has happened to the patient who is mentally ill.

> A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text of *DSM-IV* (as did the text of *DSM-III-R*) avoids the use of such expressions as "a schizophrenic" or "an alcoholic" and instead uses the more accurate, but admittedly more cumbersome, "an individual with Schizophrenia" or "an individual with Alcohol Dependence."[10]

In choosing to classify mental disorders as something people *have*, rather than as something that is inseparable from who they *are*, the makers of the *DSM* attempted to distinguish the illness from the patient. To name a patient as "an individual *with* schizophrenia" (emphasis added), and to deny that he *is* a schizophrenic (possibly in a misguided bow to political correctness), is to put distance between the person and the illness, and to think of the illness as more objective than subjective. The essential distinction made here is an ontological one between *Being* and *Having.* (Ontology is the branch of philosophy concerned with Being.) Broadly, Being is what I *am*, Having is what I *have*. In the strictest sense of the term, I can only *have* something whose existence is external to me.

The Being/Having distinction bears the wound of Western, Cartesian thinking, dividing as it does some aspect of human experience into two parts. In his existentialist diary *Being and Having*, Gabriel Marcel recognized this dichotomy as false and tried to undercut it, even as he defined it.

> … I find myself confronted with things: and some of these things have a relationship with me which is at once peculiar and mysterious. These things are not *only external*: it is as though there were a connecting corridor between them and me; they reach me, one might say, underground. In exact proportion as I am attached to these things, they are seen to exercise a power over me which my attachment confers upon them, and which grows as the attachment grows. There is one particular thing which really stands first among them, or which enjoys an absolute priority, in this respect, over them—my body … It seems that my body literally devours me, and it is the same with all the other possessions which are somehow attached or hung upon my body.[11]

The more a person's body is affected by an illness the more that body comes to seem like a possession. When one feels well, the body is a part of the good feeling, and does not announce itself as something separate and distinct. But as soon as the body is overtaken by illness, particularly when there is pain and disability, the previously taken-for-granted body comes front and center, and begins to feel foreign, like something the patient *has*. But—and Marcel helps us see why—that illness cannot be separated from who the patient *is*, either. The *DSM-IV*, in the ultimate Cartesian reduction, ripped the person out of his natural world and transformed his illness into a *thing*, something he *has* that is *not him*, which needs to be studied as a thing and treated as a thing.

Ontologically, the patient "with schizophrenia" is also "a schizophrenic." In denying this reality, psychiatry lost what it used to think of as the mind, and the patient along with it. One does not have to look beyond this jettisoning of mind, so readily acknowledged in the *DSM-IV* as a deliberate effort to avoid a "reductionistic anachronism of mind/body dualism," to understand how the practice of psychiatry has taken root in an illusion. In what is surely one of the great ironies of Western thought, the *DSM*, in attempting to avoid a reduction to the mind, created instead what amounts to a reduction to the brain. While understanding someone's life as the product of a brain that lacks the capacity of an autonomous mind, a clinician cannot possibly know what the patient's life-story narrative means, what the symptoms extracted from the story mean, what the level of pathology (if any) is, and what the diagnosis might be, let alone what the treatment should be. In place of an understanding of what it means to

be human, biological psychiatry has substituted the Holy Grail of a brain science that promises to explain mental illness, and cure it. As long as no one can prove that the Holy Grail does not exist, there is sufficient incentive for all invested parties to continue looking for it.

The illusion that biological psychiatry eventually became originated in the truth that the worst mental illnesses—correctly diagnosed schizophrenia and bipolar disorder—have roots in a disordered brain substrate. The illusion is one of extension, culminating in the claim that the biological provenance of these illnesses is the provenance of *all* pathological thinking, feeling, and behavior. In the early twentieth century, the German psychiatrist Eugen Bleuler chose the word *schizophrenia*, derived from the Greek, to signify that some of his sickest patients thought, felt, and behaved as if they had a "divided mind." In 1984, Nancy C. Andreasen, a contemporary American psychiatrist, titled a book *The Broken Brain: The Biological Revolution in Psychiatry*.[12] Like Bleuler, Andreasen saw mental illness as a compromise of the integrity, or wholeness, of the affected person. But she did not attribute the "brokenness" to the mind as Bleuler had done, or to an entity called the self, as R.D. Laing did in *The Divided Self*,[13] but to a compromised biological substrate. In biological psychiatry, mind and self are seen as broken because the brain is broken.

The downplaying of the mind that began with the publication of the *DSM-III* in 1980 was part of psychiatry's change in approach from a psychoanalytic and psychodynamic understanding of human behavior to one based on faulty brain function. From a developing, white-hot neuroscience, biological psychiatry inherited a vocabulary and syntax that replaced the vocabulary and syntax of psychoanalysis: conscious, unconscious, ego, superego, id, defense mechanism, neurosis, and psychosis were overtaken by neuron, neurotransmitter, synapse, synaptic cleft, presynaptic receptor, postsynaptic receptor, and reuptake receptor. The new language of brain science then made it possible to talk about a connection between something called a "chemical imbalance" and a mental disorder such as anxiety, depression, bipolar disorder, and schizophrenia, and to provide a rationale for prescribing drugs to correct the imbalance. Using this new vocabulary, most of the attention focused on how drugs bind to cell receptors (portals of access to cells that control the way cells function), as well as the signaling between neurons. It was posited that, by altering the structure and function of receptors in brain cells of neurons that modulate mood, cognition, and behavior, the abnormal neurotransmission presumed to underlie a mental disorder could be rectified. This is where the notion of the chemical imbalance comes from.[14]

No one who is familiar with the advances made in neuroscience and psychopharmacology during the last 50 years would deny that some

patients, usually those who were the most seriously ill, were helped by drugs introduced during this time. But with that success came the idea that *every* mental illness had a biological cause, and that the mind was an epiphenomenon. Between psychiatry, the managed care companies, and Big Pharma (a term coined to name the economic and political clout of the pharmaceutical industry), a collective illusion took hold that relegated the mind to the slag heap, along with the capacities attributed to it: consciousness, freedom, choice, and the will to power.

An illusion of this magnitude and duration could not have begun, and would not have thrived, unless it filled the needs of a large number of people. Neuroscientists and biological psychiatrists got the satisfaction of feeling they had discovered a new truth about mental illness by connecting it to a "hard" science. They saw themselves as the "good guys" who showed up the "bad guys," those psychiatrists who had been influenced by psychoanalysis, which, they said, was mired in myth and had no validity. Big Pharma saw a chance to cash in, and funded research at universities and medical schools.[15] As the market for their products grew, these companies spent enormous amounts of money trying to convince doctors and the public that their drugs were the answer to the pain and inconvenience of anxiety, depression, mood swings, and psychosis.

This new way of doing psychiatry meant that managed care companies and health maintenance organizations (HMOs) could say good-bye to the days when a patient with a mental disorder was hospitalized for months, or sometimes years. Those who were paying the bill wanted psychiatrists to start medication immediately, reduce symptoms, and discharge the patient as soon as possible for outpatient follow-up. Faster, better, cheaper.

Hospitals and psychiatrists quickly recognized the wave of the future, and followed the money. President George H.W. Bush declared 1990 to 2000 to be the "Decade of the Brain." His Presidential Proclamation listed mental illness, along with Alzheimer's disease and Parkinson's disease, as brain diseases that would eventually be conquered by medical science. The federal government poured its resources into funding the biological psychiatry juggernaut.

Once biology had been posited as the cause of most mental illness, a confluence of forces energized by this idea virtually guaranteed that psychiatry would betray itself and its patients. A giant blind spot caused by the ablated mind made it all but impossible for a psychiatrist to understand and confront what was really happening when a patient came for help with a problem. Frustration, dissatisfaction, unhappiness, guilt, anger, and even feelings of inadequacy, which collectively account for most of what is being diagnosed as mental illness now, were reconceived as medical problems.[16] This change in perspective about what mental illness

was reduced a person's complex life experience to a glitch in brain function that required correction with a drug.

A great deal is being said these days about why it is important for someone who is going into medicine, whatever the specialty, to seriously study the humanities. Medical schools are trying to break the traditional lock-step curriculum of college premed studies, which has emphasized science and rote memorization. Students interested in medical careers are being encouraged by colleges, and even medical schools, to take full majors in subjects like English, history, and psychology, while fulfilling premed requirements in biology, chemistry, and physics.

In spite of this trend, most psychiatrists are not well educated. Their training in medical school and residency does not encourage them to discover the surfaces, contours, and textures of the wider world. In fact, a grueling schedule tends to discourage them from doing so. Psychiatry, even as practiced at the highest level, is just one perspective on the world. The humanities, especially philosophy, psychology, literature, linguistics, and anthropology offer complementary views, allowing clinicians to see more deeply into the dysfunction and suffering of their patients. Psychiatrists need to have a sophisticated understanding of "normal" life so they can develop a context and a reference point for recognizing the pathological distortions in their patients' lives, and meet them in their disturbed world.

In *A Scream Goes Through the House*, subtitled *What Literature Teaches Us About Life*, Arnold Weinstein, a professor of comparative literature at Brown University, took on the question of how lives can be made better when people embrace the major texts in the Western literary canon. His work is in the tradition of the liberal arts, now devalued by a culture that is focused on technology and money-making. The liberal arts were intended to introduce a person to the world by teaching him to read, write, and think at a high level so he could live there more authentically and more freely.[17] Weinstein saw literature and art as a kind of antidote to what he calls the "shrinkage" in our lives, which is due to the limitations of the human condition itself, and to the compounding of these limitations by the life-denying ethos of our own time.

> [L]iterature and art *expand* our estate, enable us to move—conceptually, imaginatively, vicariously—out of the physical jail we (we the healthy, as well as we the sick) live in. This is not a cheat or an illusion. It is as real as the flesh that hurts, or even the death that is coming. The experience of art sets the brain and the heart going; it vitalizes and it quickens. I have argued, indeed, that it socializes and empowers, because it bids us to redefine "home" for us: art from other lands and times comes into us and enriches our estate; we move outward, into

> new territories that become ours. By offering us its special mirror, by showing how resonant and capacious the human story can be, art restores feeling to its proper place in life.[18]

To know what is pathological one must first know what is normal (a relative notion, to be sure), and getting to know the normal world is what studying the liberal arts helps us to do. I have learned as much about mental illness from a close reading of existential philosophy, novels, plays, poems, literary criticism, and from watching certain films as I have from reading the iconic texts of psychiatry and psychoanalysis. Just how one benefits from this kind of reading is hard to pin down. In his poem "Asphodel, That Greeny Flower," William Carlos Williams acknowledged how ineffable the lessons of literature can seem: "It is difficult / to get the news from poems / yet men die miserably every day / for lack / of what is found there."[19] A few simple words that appear to have been passed through a concentrating prism bring an announcement so powerful that it divides our world into the parts before and after we understood what Williams was saying.

Novelist Zoe Heller helps us to parse the "utility" of fiction when she reminds us that "literature cannot give absolute answers, or furnish watertight explanations. What it can do … is capture the moral tangle of personal life and historical context that is our lived experience."[20] Many psychiatric patients have problems that, ultimately, involve a "moral tangle" that is set in some "historical context," which is partly of their own making, and partly due to circumstance. The perspective here is distant enough to grasp the complexities of meaning and structure underlying someone's mental illness, and close enough to consider the "lived experience" of the suffering person.

Psychiatrists who do not have such an encompassing perspective, however this is achieved, work from a deficit, one that will not be disclosed by examinations taken in medical school and residency training, or for board certification. They will not be able to understand psychopathological theory, how to identify and diagnosis a mental illness from the stories patients tell, or how to take a therapeutic stand against an illness. I am convinced that this deficit is one of the reasons many psychiatrists, in spite of their excellent credentials, do not help their patients, and sometimes harm them.

Biological psychiatrists have not only ignored what can be learned from the liberal arts, they have often rejected the psychoanalytic, psychodynamic, and existential theories of the mind that were developed, refined, and tested in clinical practice during the last century. This work has been dismissed as unscientific, and replaced by theories of the brain based on neuroscience and psychopharmacology.

In spite of the emphasis traditionally put on the study of physical and biological science in medical school, psychiatrists are really not all that well trained in science, either. Most importantly, they are not equipped to evaluate the work of those scientists who generate empirical data that are used to posit a connection between some abnormal brain function and a mental disorder. The leap made from the hard science of laboratory measurements—including supposed determinations of neurotransmitter levels and real-time visualizations of brain function on the color-coded monitors of brain scanners—to the abnormal productions of consciousness is a stretch of dubious validity. In these measurements, some mental disorder is related to some marker that is related to some molecular function in some part of the brain that has been shown to be associated with feeling, thinking, and behavior. The *association* is then promoted as an *explanation* for the illness, with the implication that the illness is now *understood*. A blurring of epistemological terms is at the heart of the illusion that every mental illness is a brain illness. Giving his take on MTV, Pete Townsend, the guitarist and primary songwriter for The Who from 1964 to 1982, said: "You can speak a language there where nothing you say needs to make sense, but everyone understands you anyway."[21] This is how it is in much of the discourse that drives the illusion of biological psychiatry.

When medicine, business, the federal government, and society made the brain, rather than the mind, the major target in the effort to understand and treat mental illness, most psychiatrists bought the illusion hook, line, and sinker. Undoubtedly, an important, subconscious factor here was the pull of self-deception.[22] As the journalist Upton Sinclair recognized, "It's difficult to get a man to understand something when his salary depends on his not understanding it."[23]

A quasi-religious fervor marks the commitment of many people who are caught up in the collective illusion of biological psychiatry. It is *presumed* now that science should be the arbiter of everything significant about mental illness. It is *presumed* that science will come up with "cures"—or at least palliative strategies—for the disorders in the *DSM-IV*.

Rollo May, a psychologist whose perspective on the world was influenced by existential philosophy, challenged these presumptions.

> In our day of dedication to facts and hard-headed objectivity, we have disparaged imagination: it gets us away from "reality"; it taints our work with "subjectivity"; and, worst of all, it is said to be unscientific. As a result, art and imagination are taken as the "frosting" to life rather than as the solid food.
>
> What if imagination and art are not frosting at all, but the fountainhead of human experience? What if our logic and our

> science derive from art forms and are fundamentally dependent on them …?[24]

May is claiming that art—and this includes the liberal arts—trumps science as the way to pursue the ultimate meaning of human experience.

Contrary to what the makers of the *DSM-IV* say, having a concept of mind is compatible with the seemingly indisputable fact that some brain function underlies every thought, emotion, and act. In this sense, everything is biological. There would be no mind, no imagination, no subjectivity, and no consciousness without a functioning brain substrate, as we know from observing the consequences of trauma, dementia, and other insults to the brain. But, in spite of what biological psychiatry and the drug companies would have us believe, the data derived from a large and growing literature do not explain the essence of *any* mental illness. We simply do not know how the productions of consciousness are derived from the workings of the brain.